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ABSTRACT

Intended to inform policymaking in the public and private sectors, this booklet compiles secondary data for 59 health status indicators. The book provides both graphical and textual summaries of data and addresses long-term trends where applicable. Data are presented for the target populations of Title V funding: infants, children, adolescents, children with special health care needs, and women of childbearing age. In addition to health status, the book addresses health services utilization and population characteristics. Following the introduction, which discusses trends and issues in children's health, the booklet has six sections: (1) "Population Characteristics," including children in poverty, maternal age, working mothers, and school dropouts; (2) "Health Status," discussing the health issues related to infants, children, and adolescents; (3) "Health Services and Utilization," including health care financing, vaccination coverage levels, physician visits, service utilization by children with chronic conditions, hospital utilization, and prenatal care; (4) "State-Specific Data," including data tables on infant and neonatal mortality, prenatal care, low birth weight, births to women under 18, Medicaid information, and health insurance; (5) "City Data," focusing on comparisons between cities with populations over 100,000 and national data on infant mortality, low birth weight, and prenatal care; and (6) "Healthy People 2010 Objectives." (Contains 34 references.) (EV)

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Child Health USA 2000

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Dear Colleague:

The Health Resources and Services Administration's Maternal and Child Health Bureau (MCHB) is pleased to present Child Health USA 2000, the eleventh annual report on the health status and service needs of America's children. To assess the Bureau's progress toward achieving its vision for a Nation where all individuals enjoy equal access to quality health care in a supportive, culturally competent, family and community setting, MCHB has compiled this book of secondary data for 59 health status indicators. It provides both graphical and textual summaries of data and addresses long-term trends where applicable.

Data are presented for the target populations of Title V funding: infants, children, adolescents, children with special health care needs, and women of childbearing age. In addition to population characteristics, this book also addresses health status and health services utilization. Child Health USA 2000 also provides insight into the Nation's progress toward the goals set out in the MCHB's strategic plan—to eliminate barriers and health disparities, to assure quality of care, and to improve the health infrastructure and system.

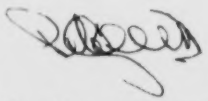
Child Health USA is published to provide the most current data available for public health professionals and other individuals in the private and public sectors. The book's succinct format is intended to facilitate the use of the information as a snapshot of measures of children's health in the United States.

The first section, Population Characteristics, presents statistics on factors that influence the well-being of children. The second section, entitled Health Status, contains vital statistics and health behavior information for infants, children, adolescents, and women of childbearing age. The third section, Health Services Utilization, contains data regarding health care financing and newly implemented health policies. The fourth and fifth sections contain information on selected indicators at the state and city levels. This edition also includes a special section that lists the Healthy People 2010 Objectives for Maternal, Infant, and Child Health.

Please note that Child Health USA 2000 is not copyrighted. Readers are free to duplicate and use all or part of the information contained in this publication. The book is available online at http://www.mchb.hrsa.gov. Single copies of this publication are also available at no cost from the National Maternal and Child Health Clearinghouse, 2070 Chain Bridge Road, Suite 450, Vienna, VA 22182-2536, telephone: (703) 356-1964 or (888) 434-4624.

I hope the information provided in Child Health USA 2000 is a valuable resource for your efforts to plan, implement, or expand programs that affect the health of children in the United States.

Sincerely yours,



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Associate Administrator for Maternal and Child Health

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INTRODUCTION

Early childhood is a critical time in children's physical, emotional, and intellectual development, a time when children's environment can have the greatest influence on their future success. In addition to the effect of positive relationships with parents and caregivers and the influence of early childhood education on the social and intellectual development of children, many important steps taken before and soon after birth can greatly influence children's health and physical development. These include early and adequate prenatal care, breastfeeding, and immunization. Fortunately, the United States has seen progress in recent years in many of these areas. However, many threats to the lives and health of young children (as well as older children and adolescents) remain, and significant effort is still needed to assure the healthy development of America's children.

One of the earliest steps we can take for children's health is to assure that pregnant women have access to prenatal care early in pregnancy and that they receive appropriate care throughout pregnancy. In 1998, the percentage of births to women who received early prenatal care (beginning in the first three months of pregnancy) went up for the ninth consecutive year, with nearly 83 percent of women receiving care in the first trimester. However, this percentage is significantly lower for minority women; only 73 percent of African-American mothers and 74 percent of Hispanic mothers received early care. African-American and Hispanic women are also more likely to begin care late in pregnancy or to deliver with no prenatal care at all.

Young mothers are particularly likely to enter prenatal care late in pregnancy, and the children of teenage mothers are more likely to face economic, health, and developmental challenges. Another area in which we have seen progress, is in the rate of births to adolescent women. In 1998, the birth rate among adolescents was 51 births per 1,000 women aged 15-19, the lowest rate reported since 1987. However, again, teen birth rates are much higher within minority groups: for African-Americans, the adolescent birth rate in 1998 was 85 births per 1,000 women 15-19, and for Hispanics, the rate was 94 births per 1,000 women.

Breastfeeding is another important contributor to the health of young children, and rates of breastfeeding have also shown improvement in recent years. Breast milk has a number of preventive health benefits for both mother and child. The benefits of breastfeeding include prevention of diarrhea and infections in infants, as well as long-term preventive effects for the mother, including earlier return to pre-pregnancy weight and reduced risk of premenopausal breast cancer and osteoporosis. In 1998, more than 64 percent of mothers reported breastfeeding their babies right after delivery, the highest rate in recent years. However, rates of breastfeeding decline dramatically after the initial months of life, and only 29 percent report that they are still breastfeeding their infants at 6 months of age. These rates are even lower among African-American women and young mothers; 45 percent of African-American women report breastfeeding in the hospital, and only 19 percent breastfed at 6 months.

An early indicator of the health of infants is their birth weight. Babies born at low birth weight (less than 2500 grams, or 5.5 pounds) are most susceptible to physical disabilities, developmental delays, and infant death. Despite improvements in the use of prental care, the rate of low birth weight has actually risen in recent years; the rate reported in 1998 was 7.6 percent of all live births, which is similar to the rates seen thirty years ago. However,

the causes of these rates of low birth weight appear to be changing. The recent increases in the low birth weight rate, at least among white women, can be attributed to increases in the rate of multiple births, as twins and triplets are at particular risk for being small at birth. Another important risk factor for low birth weight is smoking during pregnancy.

Another sentinel indicator of the health of young children is the rate of infant mortality. In 1998, the infant mortality rate remained steady at 7.2 deaths per 1,000 live births, the lowest rate ever recorded in the U.S. However, this rate still ranks 26th among the industrialized nations of the world. In addition, the mortality rate among African-American infants is still more than twice that of whites. The leading causes of neonatal mortality, or death in the first 28 days of life, are birth defects and disorders related to short gestation (preterm delivery) and low birth weight. Neonatal deaths make up two-thirds of all infant deaths. The leading causes of postneonatal mortality, or death between 28 days and 1 year of age, are Sudden Infant Death Syndrome, or SIDS, and birth defects. The rate of SIDS has dropped dramatically in the past five years, as parents and caregivers have learned about the importance of putting infants down to sleep on their backs.

As children grow, preventive health care is essential for monitoring their health and development and assuring that they receive the recommended series of immunizations. The percentage of 19- to 35-month-old children who had been fully immunized in 1998 was the highest ever recorded, with 78 percent of children receiving all recommended vaccines. However, approximately 1 million children still need one or more of the recommended doses of vaccine to be fully protected.

Children are more likely to have access to both preventive and acute health care, in infancy and throughout childhood and adolescence, if they have a source of comprehensive health coverage. In 1998, nearly 16 percent of children, or over 11 million children, were uninsured, a proportion that was unchanged from 1997. This proportion varies across the country, from 6 percent in Nebraska to 26 percent in Arizona and Texas. However, the implementation of the State Children's Health Insurance Program in all 50 states has improved access to health insurance for low-income children, and by the end of 1999 these programs had enrolled two million children.

The major risks to children's health and development, particularly after infancy, are largely preventable. The leading cause of death for children over age 1 is injury, including motor vehicle crashes, firearms (including homicides), and drowning. In 1998, injuries caused the deaths of 6,420 children under age 15. Other leading causes of death in childhood are birth defects and malignant neoplasms, or cancer.

As we focus our attention on the health and developmental needs of young children, we must not forget that adolescence is another critical period in children's lives. Lifetime health habits, both positive and negative, are formed during the teenage years, and the groundwork is laid for the health of the next generation. While most adolescents are generally healthy, significant threats to adolescent health remain. One of the greatest of these threats is cigarette smoking, which, when begun in the teen years, can have lifelong health consequences. In 1999, the percentage of eighth-graders who smoke decreased to 18 percent, while the percentage of tenth- and twelfth-graders who smoke remained steady at 26 and 35 percent, respectively. The prevalence of smoking among teens has increased substantially since 1991.

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Other important threats to the lives and health of adolescents include injury, particularly motor vehicle crashes, the leading cause of death among teens aged 15-19; sexually transmitted diseases; substance abuse; and violence. Motor vehicle crashes caused the deaths of 5,213 15- to 19-year-olds in 1998, and firearms were the cause of death for another 3,593 adolescents. The number of AIDS cases reported in adolescents and young adults has declined in recent years, and rates of other reportable sexually transmitted diseases, including chlamydia, gonorrhea, and syphilis, appear to be decreasing as well. However, STDs still affect thousands of adolescents and young adults each year and can have lasting health effects if not adequately treated.

The statistics presented here paint a picture of continuing progress toward the goal of healthy children and families, but we still have a long way to go in many areas. On the National level, the U.S. Department of Health and Human Services has launched Healthy People 2010, a revised set of health objectives for the Nation that focuses on two major goals: increasing the quality and years of healthy life and eliminating health disparities. These goals are reflected in 467 specific objectives, developed by a consortium of government, voluntary, and professional organizations, in 28 focus areas. The 23 objectives in the Maternal, Infant, and Child Health focus area are included here. Although the methods used to calculate the specific statistics in this book may not precisely coincide with the way these national and state-level objectives are measured, the information presented here will provide readers with timely and accurate data that allows for an overview of the current status of child health.

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POPULATION CHARACTERISTICS

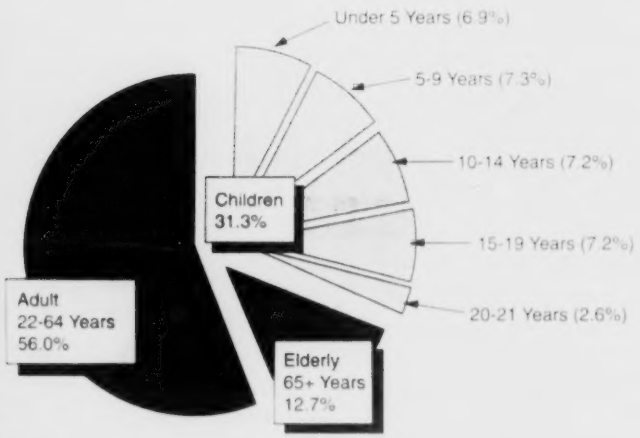
Socio-demographic characteristics provide a comprehensive picture of the country's diverse maternal and child population. The proportion of children ages 21 and below comprises roughly one-third of the U.S. population.

At the national, state, and local levels, policy-makers use population information to systematically address health-related issues of mothers and children. By carefully analyzing and comparing data, health workers can often isolate high-risk populations that require specific interventions. Policy-makers can then tailor programs to meet the needs of those populations.

The following section presents data on several population characteristics that have an impact on maternal and child health program development and evaluation. These include age, poverty status, living arrangements by head of household, school dropout rates, and child care trends.

U.S. RESIDENT POPULATION BY AGE GROUP: JULY 1, 1999

Source (1): U.S. Bureau of the Census



POPULATION OF CHILDREN

In 1999, the 85 million children through the age of 21 in the United States represented 31.3 percent of the total population, adults aged 22-64 accounted for 56 percent, and persons aged 65 and over represented 12.7 percent of the total population. The median age in the United States for all races was 35.5.

Since 1990, the number of children under 5 years of age has increased by .5 percent. The number of children ages 5-19 years has increased by 11.7 percent. In the same period, the number of persons aged 65 and over has increased 10.6 percent.

CHILDREN IN POVERTY

In 1998, there were 12.8 million related* children under 18 years of age living in families with income below the Federal poverty level of $16,660** for a family of four. This figure reflects a 4.3 percent decrease from 1997. This population comprised 18.3 percent of all related children living in families. Though the proportion of children living in poverty is declining, a greater percentage of black and Hispanic children are poor compared to white children. One in seven white children are poor compared to one in three black and Hispanic children.

Although the number of children in poverty has fallen by approximately 577,000 since 1997, this number still represents 1.7 million more children than were reported to be living in poverty in 1980. Over this same period, the number of persons 65 years of age and over living in poverty decreased by almost 500,000.

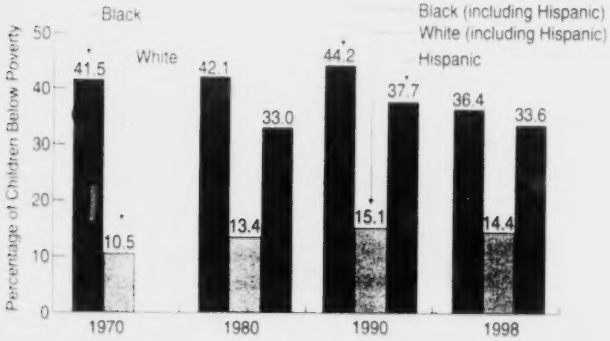
Of the 12.8 million related children under 18 years of age living in poverty, 59.4 percent live in homes headed by a single mother, 35.4 percent live in homes headed by married parents, and 5.2 percent live in families with other compositions.

**Related children in a family includes householder's own children and all other children in the household who are related to the householder by blood, marriage, or adoption.*

***Based on the U.S. Census Bureau's poverty threshold, which is calculated using the Consumer Price Index from the previous calendar year.*

RELATED CHILDREN UNDER 18 YEARS OF AGE LIVING IN FAMILIES BELOW 100% OF POVERTY LEVEL BY RACE/ETHNICITY: 1998

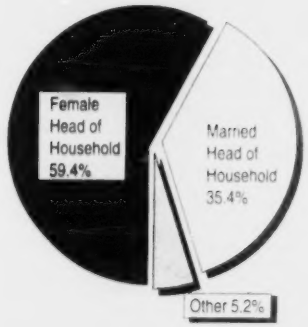
Source (L2): U.S. Bureau of the Census



Hispanic ethnicity not reported prior to 1979.

RELATED CHILDREN UNDER 18 YEARS OF AGE LIVING IN FAMILIES BELOW 100% OF POVERTY LEVEL, BY HOUSEHOLD STATUS: 1998

Source (L2): U.S. Bureau of the Census



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SCHOOL DROPOUTS

As of October 1998, approximately 479,000 youths ages 15–24 had dropped out of high school in the previous 12 months. Those who dropped out of high school during this period represented 4.8 percent of students enrolled in high school in 1997.

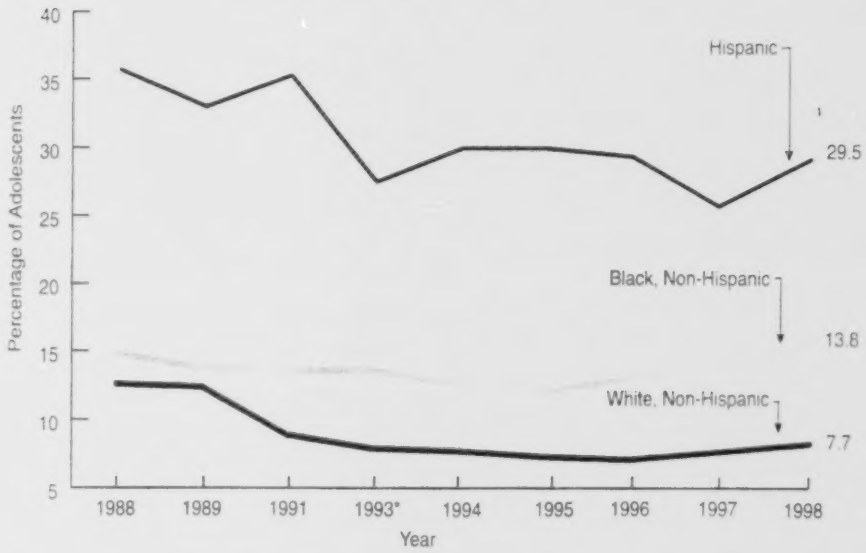
In 1998, Hispanic students were the most likely to drop out, and dropouts represented over one-fourth of Hispanic young adults. The 1998 data represents a 16.6 percent increase from the 1997 Hispanic dropout rates. Both the white and black dropout rates increased slightly between 1997 and 1998.

Those students most likely to drop out of school in 1998 were those living in the western states, boys, and students aged 19 and older. Also, students living in low-income families were four times more likely to drop out of high school than those in higher-income families.

Note: Status rates measure the proportion of the population who have not completed high school and are not enrolled at one point in time, regardless of when they dropped out.

STATUS SCHOOL DROPOUT RATES FOR AGES 16-24 BY RACE/ETHNICITY: 1988-1998

Source 13): U.S. Department of Education



**Because of changes in data collection procedures beginning in 1992, data may not be comparable with figures for earlier years.*

WORKING MOTHERS

In 1999, 65 percent of mothers with preschool aged children (younger than 6 years) were in the labor force (either employed or looking for work), and 61 percent were actually employed. Of those mothers, 70 percent were employed full-time and 30 percent worked part-time.

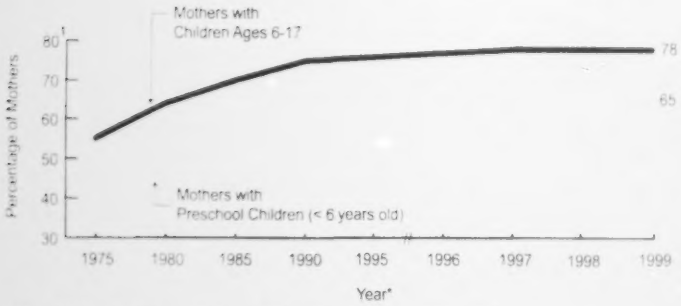
Of women with children ages 6-17, 78 percent were in the labor force in 1999 and 75 percent were actually employed. Of employed mothers, 77 percent worked full-time and 23 percent worked part-time.

CHILD CARE

In 1997, 41 percent of children under 5 years of age whose mothers worked were cared for by persons other than their parents for 35 or more hours per week. While 42 percent of children in families with higher incomes spent more than 35 hours a week in some form of child care, slightly less, or 40 percent of children in lower-income families, were in care for the same number of hours. However, a smaller proportion of children from low-income families (21 percent) were in part-time care compared to higher-income children (27 percent). Children three and four years old were more often i multiple child care arrangements (44 percent compared to younger children (34 percent).

MOTHERS IN THE WORK FORCE: 1975-1999

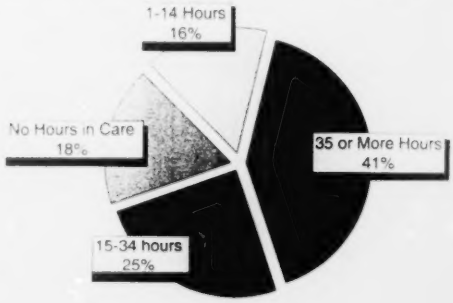
Source (14): U.S. Bureau of Labor Statistics



Data for 1995 are not strictly comparable with data for earlier years due to changes in the survey and the estimation process.

HOURS PER WEEK SPENT IN CHILD CARE BY CHILDREN UNDE FIVE WITH WORKING MOTHERS: 1997

Source (15): National Survey of America's Families, The Urban Institute



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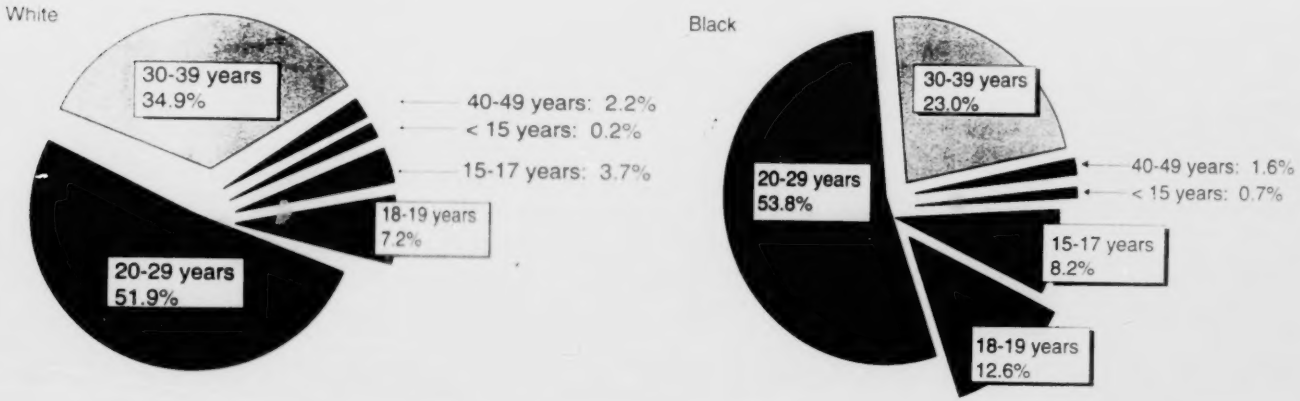
MATERNAL AGE

In 1998, for the first time since 1990, the total US birth rate increased from the previous year. While birth rates among teenagers continued to decline, birth rates for women in their twenties, thirties, and forties continued to increase. In fact, the birth rate for women in their thirties has not been this high since the mid-1960s. Of all births in 1998, just over half were to women in their twenties, one third were to women in their thirties, and 12.5 percent were to teens. The remaining 2 percent of births were to women in their forties.

Among both black and white women, more than half of births in 1998 were to women in their twenties. However, a substantially higher proportion of white births were to women in their thirties and forties while the percentage of births to teens was almost twice as high among blacks as among whites.

PERCENT DISTRIBUTION OF BIRTHS BY MATERNAL AGE, BY RACE, 1998

Source (1.6): National Center for Health Statistics



HEALTH STATUS

The systematic assessment of the health status of children enables health professionals to determine the impact of past and current health intervention and prevention programs. Program planners and policy-makers identify trends by examining and comparing information from one data collection year to the next. Although indicators are often assessed on an annual basis, some surveillance systems may only collect data every two, three, or five years.

In the following section, mortality, disease, injury, and health behavior indicators are presented by age group. The health status indicators in this section are based on vital statistics and national surveys. Population-based samples are designed to yield data that are representative of the maternal and child population that are affected by, or in need of, specific health services.

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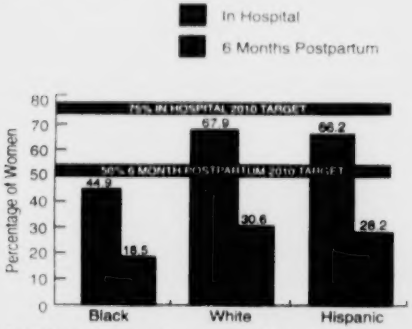
BREASTFEEDING BY RACE: 1998*

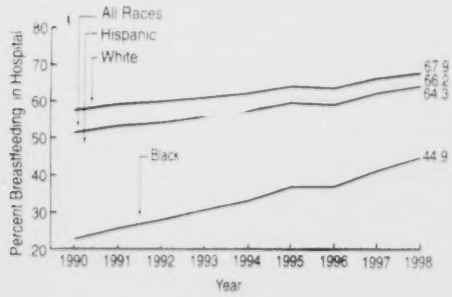
Source (II.1): Abbott Laboratories



*Includes exclusive and supplemented breastfeeding

BREASTFEEDING BY RACE: 1990-1998

Source (II.1): Abbott Laboratories



INFANT FEEDING

Throughout the 1970's and early 1980's, the percentage of mothers who began breastfeeding in the hospital increased steadily to 61.9 percent, but then gradually declined to 51.5 percent by 1990. Since 1991, an increase in rates for black, Hispanic, and white women has produced a rate of 64.3 percent in 1998, the highest in recent years.

Since 1990, rates of breastfeeding immediately after delivery grew the most among groups of mothers that have traditionally been the least likely to breastfeed, such as black and Hispanic women. Over the past nine years, the rate of breastfeeding has nearly doubled among black women and has increased 38 percent among Hispanic mothers. These increases have contributed to a substantial reduction in the gap in breastfeeding rates between white and non- white women.

Breastfeeding rates for women of all races decrease substantially between delivery and 6 months postpartum, the breastfeeding period recommended as most critical for the infant's health by the Surgeon General of the United States. The percentage of women who report that they are still breastfeeding at 6 months postpartum in 1998 increased from the previous year. However, only 30.6 percent, 28.2 percent, and 18.5 percent of white, Hispanic, and black women respectively were still breastfeeding at six months postpartum. These rates represent a sharp decline from rates immediately after delivery of 67.9 percent among whites, 66.2 percent among Hispanics, and 44.9 percent among blacks.

Breastfeeding rates were highest among women over 35 years of age, college educated, not participating in the Women, Infants, and Children (WIC) dietary supplement program, and/or living in the western states. Women were also more likely to breastfeed their first child. Women least likely to breastfeed were younger than 20 years of age, not employed, low-income, black and/or living in the southeastern United States.

LOW BIRTH WEIGHT

In 1998, 298,208 babies (7.6 percent of all live births) were of low birth weight, weighing less than 2,500 grams, or about 5.5 pounds, at birth.

The percentage of newborns born at low birth weight rose from a low of 6.8 percent in 1985 to 7.6 percent in 1998 and currently rivals the rates reported nearly thirty years ago. Some of the incidence of low birth weight is due to an increase in the proportion of multiple births, as these infants are at a much greater risk of weighing less than 2,500 grams at birth. In fact, the increase in low birth weight from 1997 to 1998 has been entirely attributed to multiple births. Low birth weight among singleton births actually decreased slightly, from 6.08 percent in 1997 to 6.05 percent in 1998.

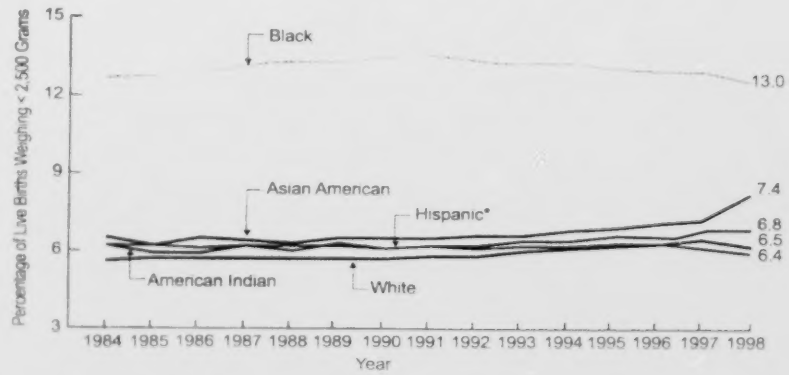
The increase in low birth weight is largely attributable to the increase in multiple births among white women. Although the rate of low birth weight is still twice as high among infants born to black women (13 percent), the decline in singleton low birth weight since 1989 is greater for black women than for the total population.

Low birth weight is the factor most closely associated with neonatal mortality. Low birth weight infants are more likely to experience long-term disabilities or to die during the first year of life than are infants of normal weight.

In 1998, 12.0 percent of infants born to smokers were of low birth weight, compared with 7.2 percent of births to nonsmokers. This nearly twofold differential has been observed since 1989 among both black and white infants. Other factors associated with increased risk of low birth weight include poverty and low levels of educational attainment.

PERCENTAGE OF INFANTS BORN AT LOW BIRTH WEIGHT BY RACE: 1984-1998

Source (IL2) National Center for Health Statistics



*Hispanic can be of any race.

Note: 1984-1988 data based on race of child, 1989-1998 data based on race of mother.

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VERY LOW BIRTH WEIGHT

In 1998, rates of very low birth weight remained at approximately 1.4 percent of live births to U.S. women.

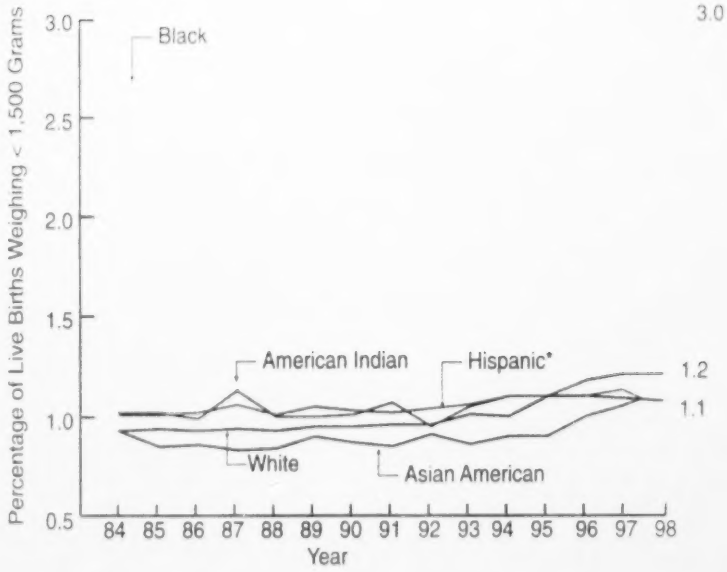
Although infants weighing less than 1500 grams (about 3.3 pounds) account for a small percentage of births, they account for up to half of the newborns. Approximately 9 of 10 of the very smallest infants—those with birth weights of less than 500 grams—die within the first year of life.

Very low birth weight infants who survive are at significantly increased risk of severe problems, including physical and visual difficulties, developmental delays and cognitive impairment requiring increased levels of medical, educational and parental care.

The rate of very low birth weight among black babies is almost three times as high as that among whites, and is more than twice the rate for the total population. This disparity is a major contributor to the disparity in infant mortality rates between black and white infants.

PERCENTAGE OF INFANTS BORN AT VERY LOW BIRTH WEIGHT BY RACE: 1984-1998

Source (II.2): National Center for Health Statistics



* Hispanic can be of any race.

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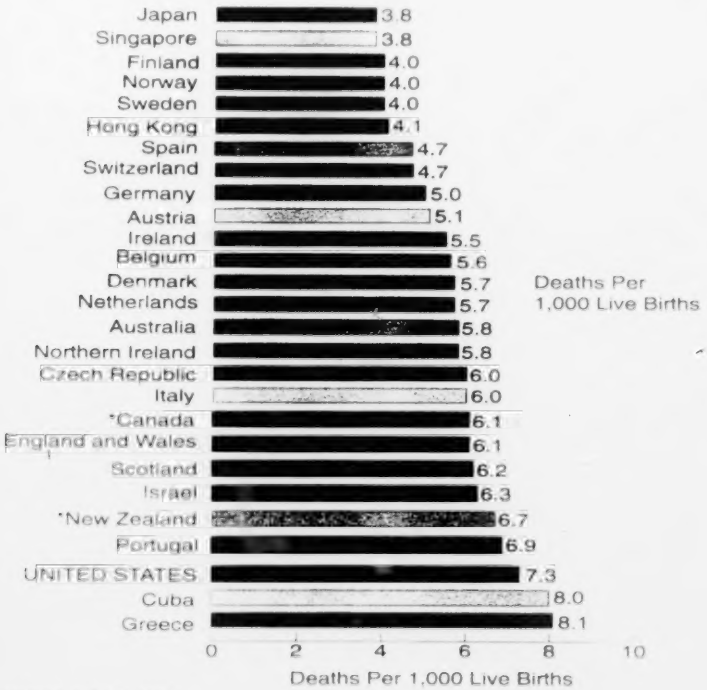
COMPARISON OF NATIONAL INFANT MORTALITY RATES: 1996

Source (II.3): National Center for Health Statistics



*Rates are for 1995

COMPARISON OF NATIONAL INFANT MORTALITY RATES

Differences in the infant mortality rates among industrialized nations reflect differences in the health status of women before and during pregnancy and the quality of primary health care accessible to pregnant women and their infants. Although the United States has greatly reduced its infant mortality rate since 1965, the Nation dropped one rank to 26th among industrialized countries in 1996.

In 1996, two nations reported the lowest recorded rates of infant mortality in history — Singapore and Japan. The risk of a Japanese child dying in infancy (3.8 per 1,000 live births) was 48 percent lower than that observed in the United States (7.3 per 1,000).

INFANT MORTALITY

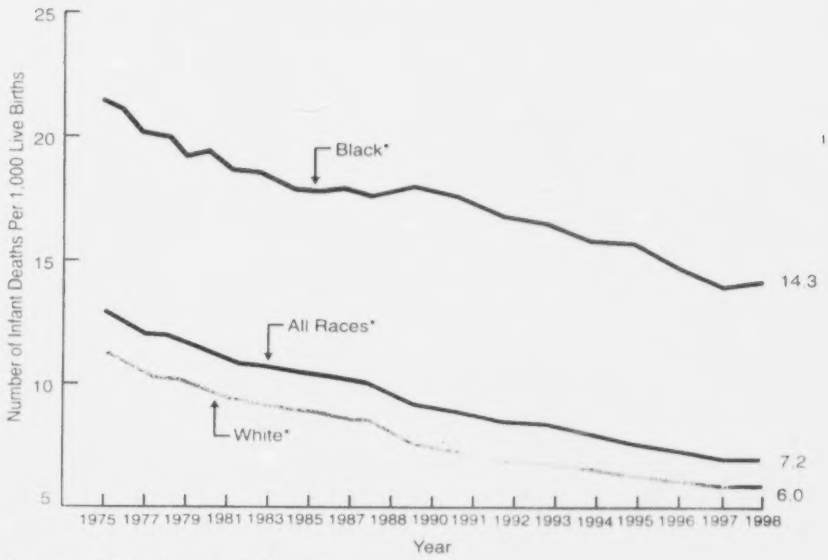
In 1998, 28,371 infants died before their first birthday. The infant mortality rate was 7.2 deaths per 1,000 live births. This rate was unchanged from 1997.

The rapid decline in infant mortality, which began in the mid 1960s, slowed for both blacks and whites during the 1980s. Between 1997 and 1998, the rate of death among white infants remained unchanged at 6.0, while the rate for blacks increased from 14.2 to 14.3.

The 1998 infant mortality rate for black infants was 2.4 times the rate for white infants. Although the trend in infant mortality rates among blacks and whites has been on a continual decline throughout the 20th century, the proportional discrepancy between the black and white races has remained largely unchanged.

U.S. INFANT MORTALITY RATES BY RACE OF MOTHER: 1975-1998

Source (II.4): National Center for Health Statistics



*Includes the ethnic classification of Hispanic.

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NEONATAL AND POSTNEONATAL MORTALITY

Neonatal

In 1998, 18,918 infants younger than 28 days died, resulting in a neonatal mortality rate of 480.0 deaths per 100,000 live births. Both the overall mortality rate and rates by the leading causes of mortality were not statistically different from 1997 to 1998.

Disorders resulting from short gestation and low birth weight are the primary causes of neonatal mortality for blacks, while congenital anomalies are the leading causes for whites.

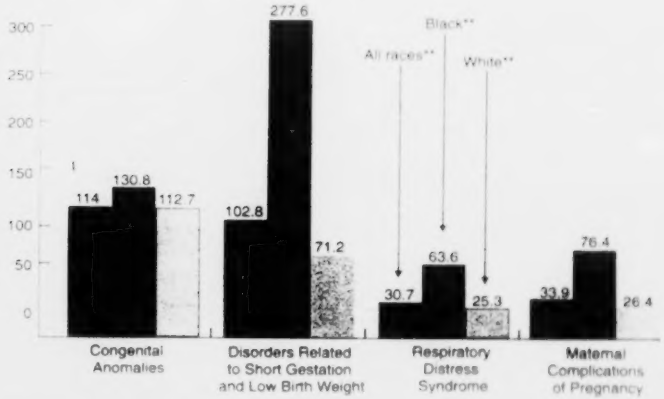
Postneonatal

In 1998, 9,453 infants 28 days to 11 months old died; the postneonatal mortality rate was 239.8 deaths per 100,000 live births, which represents a 2.2 percent decline from 1997.

The postneonatal mortality rate for blacks is at least two times that for whites for most of the leading causes of postneonatal mortality.

LEADING CAUSES OF NEONATAL* MORTALITY: 1998

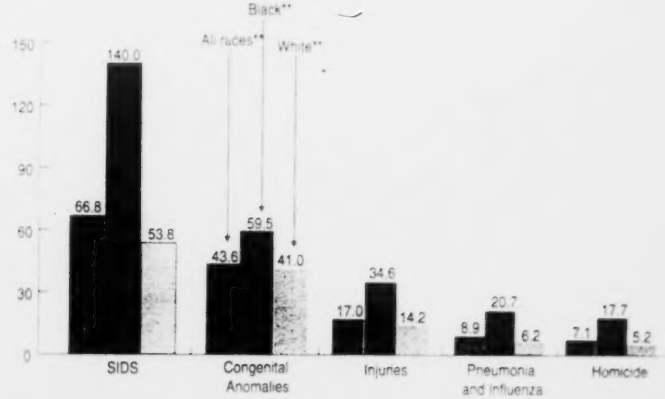
Source: [14]: National Center for Health Statistics



*Neonatal: less than 28 days old
**Includes Hispanic

LEADING CAUSES OF POSTNEONATAL* MORTALITY: 1998

Source: [14]: National Center for Health Statistics



*Postneonatal: 28 days to less than 1 year old
**Includes Hispanic

MATERNAL MORTALITY

During the past several decades, there has been a dramatic decrease in maternal mortality in the United States. Since 1980, however, the rate of decline has slowed, and the maternal mortality rate was not statistically different in 1998 than in 1997.

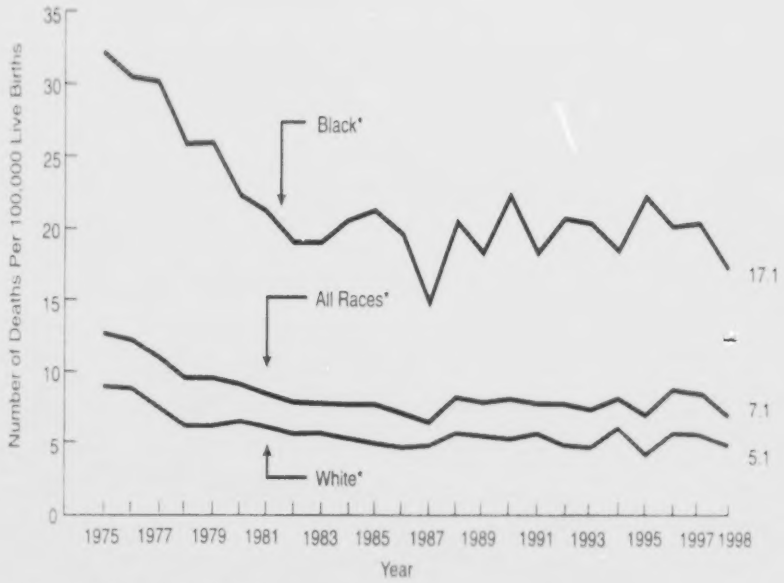
In 1998, there were 281 maternal deaths which resulted from complications during pregnancy, childbirth, or the postpartum period.

The maternal mortality rate for black women (17.1 per 100,000 live births) is more than three times the rate for white women (5.1 per 100,00 live births).

Regardless of race, the risk of maternal death increases for women over age 30; women 35-39 years old have approximately twice the risk of maternal death than those aged 20-24 years.

MATERNAL MORTALITY RATES BY RACE OF MOTHER: 1975-1998

Source: II.4): National Center for Health Statistics



*Includes the ethnic classification of Hispanic

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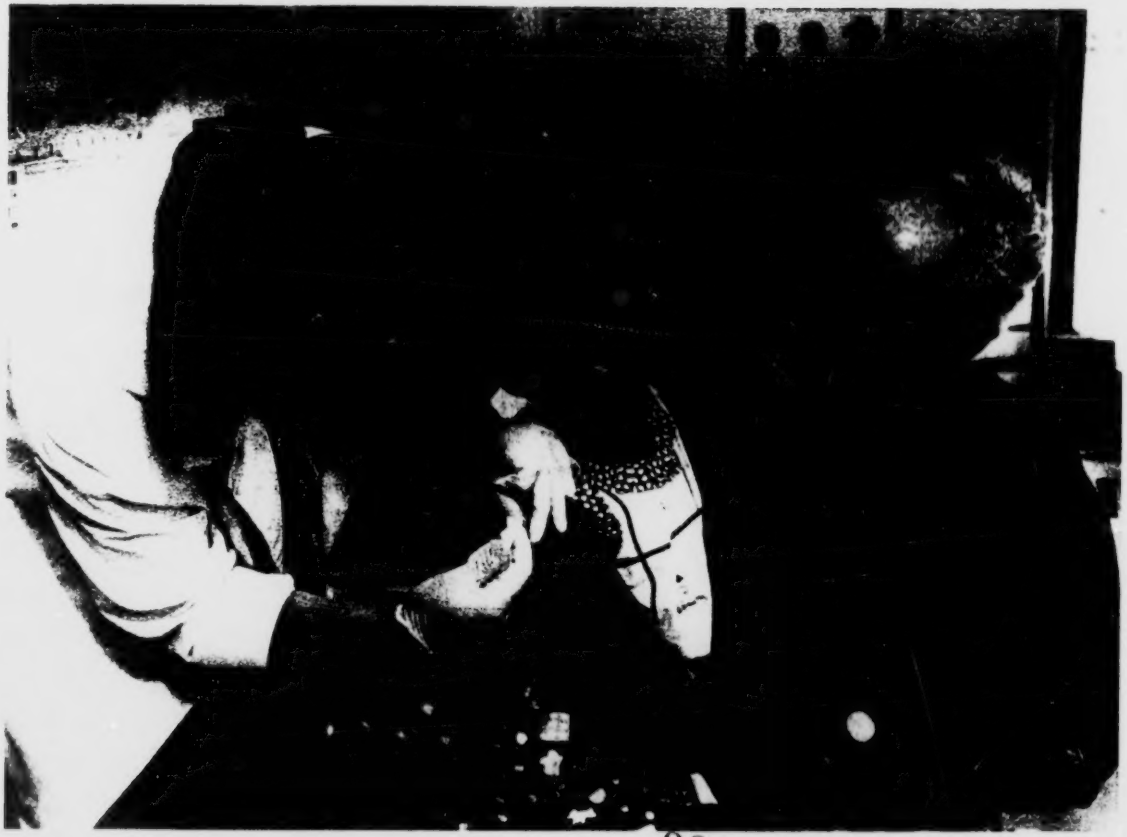


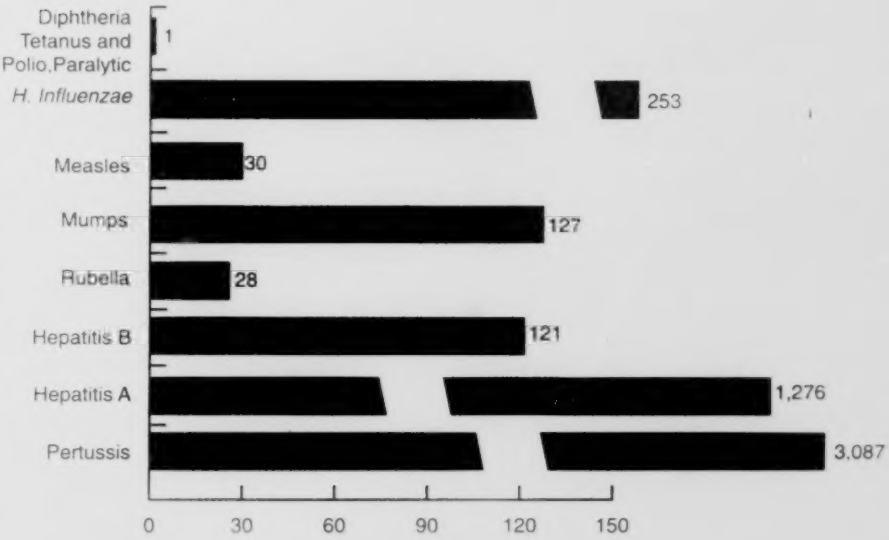
VACCINE-PREVENTABLE DISEASES

The number of reported cases of vaccine-preventable diseases has decreased steadily since the introduction of the Childhood Immunization Initiative. While the number of cases of rubella and pertussis increased among children under 5 from 1997 to 1998, the number of measles cases decreased, and diphtheria, mumps, and polio remained the same. Our progress in the control of vaccine-preventable diseases is exemplified in the decline in the number of cases of measles in children since the measles epidemic of the late 1980s. Also significant is the near-eradication of polio, with just one case reported in 1998 among children under 5 years of age.

Although much progress has been made in reducing the number of reported cases of vaccine-preventable diseases, several of these diseases are still common. The number of cases of pertussis and mumps remains substantial and indicates a need to continue to promote immunization efforts.

NUMBER OF CASES OF REPORTABLE VACCINE-PREVENTABLE DISEASES AMONG CHILDREN UNDER 5: 1998

Source (II.5): Centers for Disease Control and Prevention



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CHILD ABUSE AND NEGLECT

In 1998, investigations by state child protective services agencies determined that approximately 903,000 children were victims of substantiated or indicated child abuse or neglect, equivalent to a rate of 12.9 per 1,000 children younger than 18 years of age. Eighty-seven percent of the perpetrators of child maltreatment were the parents of the victims.

Approximately 56 percent of all victims suffered neglect, 23 percent physical abuse, 12 percent sexual abuse, 6 percent emotional maltreatment, and 25 percent other forms of maltreatment. Some children suffered multiple types of maltreatment.

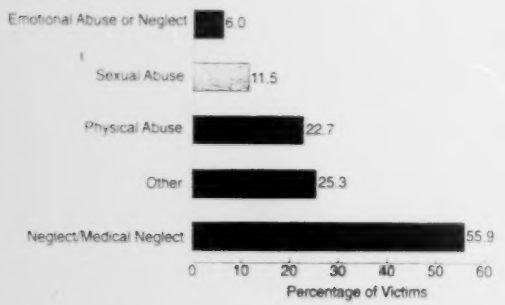
Data from 39 states show that the youngest children suffered the most abuse and neglect. The victimization rate declines steadily with age. In 1998, the victimization rate for children ages 0 to 3 was 14.7 per 1,000 children compared to 6.6 per 1,000 children ages 16 to 17.

An estimated 1,100 children died from abuse or neglect in 1998. Available data suggest that more than three-quarters of children dying from abuse and neglect were under age 5.

The National Child Abuse and Neglect Data System (NCANDS) is the primary source of national information on abused and neglected children known to state child protective services agencies. In 1998, state child protective services agencies received reports alleging the maltreatment of roughly 2,800,000 children. A little more than half of the reports were from community professionals and the remaining reports came from members of the general public (such as family, friends, relatives, or neighbors of the reported children).

PERCENTAGE OF CHILD ABUSE AND NEGLECT VICTIMS BY TYPE OF MALTREATMENT: 1998

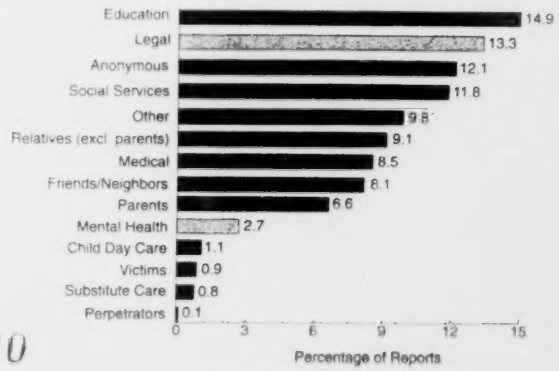
Source (II.6): U.S. Department of Health and Human Services



Note: Percentage totals more than 100% because some states report more than one type of maltreatment per victim. Includes victims in 48 states.

SOURCES OF MALTREATMENT REPORTS: 1998

Source (II.6): U.S. Department of Health and Human Services



Note: 1,702,904 reports from 45 states.

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PEDIATRIC AIDS

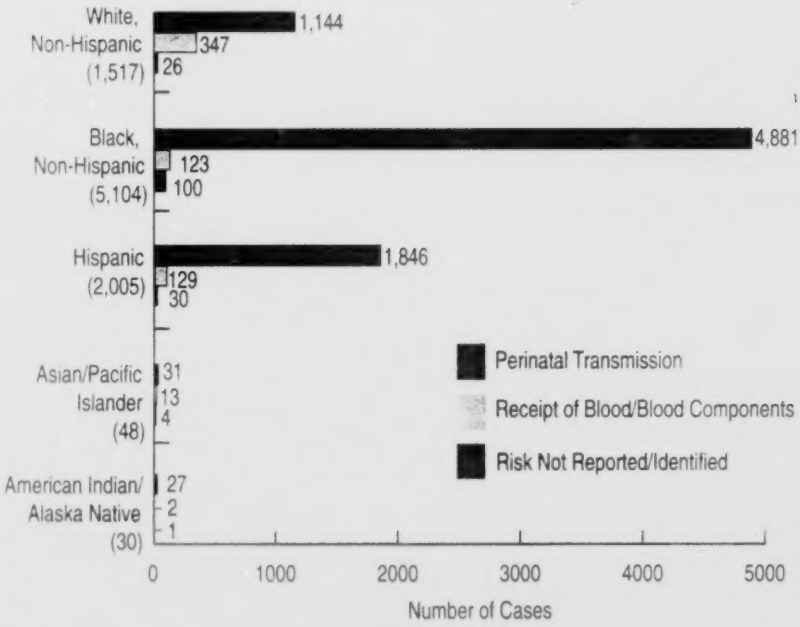
As of December 31, 1999, 8,718 cases of AIDS in children younger than 13 had been reported in the U.S.; this total includes 263 newly reported cases in 1999. Pediatric AIDS cases represented less than 1.2 percent of all cases reported to date.

The majority of pediatric AIDS cases result from transmission before or during birth (perinatal transmission). However, the number of new cases of pediatric AIDS due to perinatal transmission has declined by 69 percent since 1993. A major factor in this decline is the increasing use of zidovudine (ZDV) treatment during pregnancy to reduce perinatal HIV transmission. In 1994, the U.S. Public Health Service recommended this treatment for all HIV- positive pregnant women, and in 1995, routine HIV counseling and voluntary testing for all pregnant women were recommended. It is expected that the perinatal transmission rate will continue to decline with increased use of aggressive treatments and obstetric procedures, such as elective cesarean section.

The number of pediatric AIDS cases ever reported in black, non-Hispanic children is more than three times that of white, non-Hispanic children and two and one-half times that of Hispanic children.

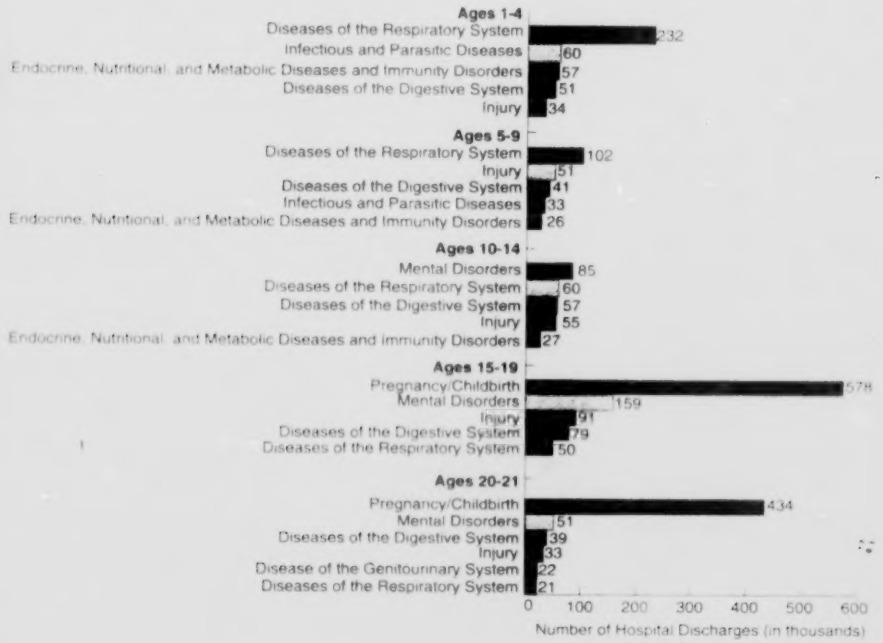
PEDIATRIC AIDS BY RACE/ETHNICITY AND EXPOSURE CATEGORY: 1981-1999

Source (II.7): Centers for Disease Control and Prevention



MAJOR CAUSES OF HOSPITALIZATION BY AGE: 1998

Source (II.8): National Center for Health Statistics



HOSPITALIZATION

In 1998, there were 3.4 million hospital discharges of children 1 through 21 years old, or 4.1 discharges per 100 children that year.

Diseases of the respiratory system were the major causes of hospitalization for children 1-9 years of age and accounted for 31 percent of their discharges.

Hospital discharge rates generally decrease until about age 10 and then increase during later adolescence.

While injuries are the leading cause of death for children older than 1 year, this category accounted for only 9 percent of the hospital discharges of children 1-14 years old in 1998. Pregnancy and childbirth accounted for 69 percent of discharges of young women ages 15-21.

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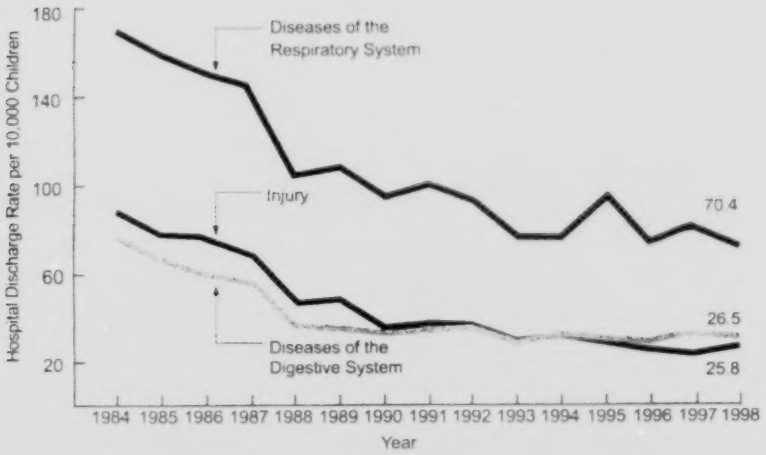
DISCHARGE RATE OF PATIENTS 1-14 YEARS OLD FOR SELECTED DIAGNOSES: 1984-1998

Source (II.8): National Center for Health Statistics



HOSPITAL DISCHARGE TRENDS

Since 1984, there has been a 45 percent decrease in overall hospital discharge rates for children aged 1-14 years.

Between 1984 and 1998, there was a 50 percent decline in the hospital discharge rate for diseases of the respiratory system in children in this age group.

Three diagnostic categories (respiratory diseases, injury, and digestive diseases) accounted for 45 percent of the discharges of children aged 1-14 years in 1998.

CHILD MORTALITY

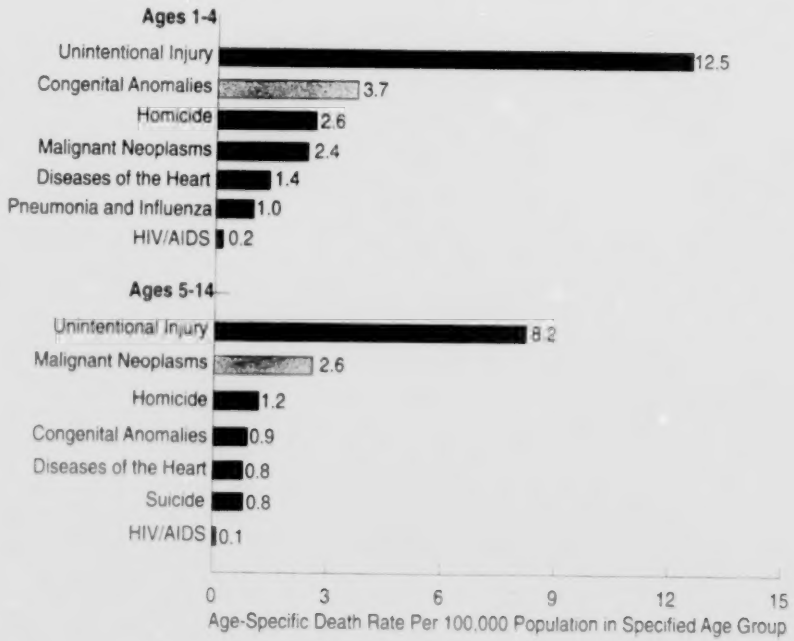
There were 13,042 deaths of children ages 1-14 in 1998. Injury, regardless of intent, was the primary cause of death in that age group. Among 1-4 year old children, injuries accounted for 44 percent of all deaths, followed by deaths due to congenital anomalies (birth defects), homicide, malignant neoplasms (cancer), and diseases of the heart.

Injuries comprised 47.7 percent of all deaths among 5-14 year old children, followed by malignant neoplasms, homicide, congenital anomalies, diseases of the heart, and suicide.

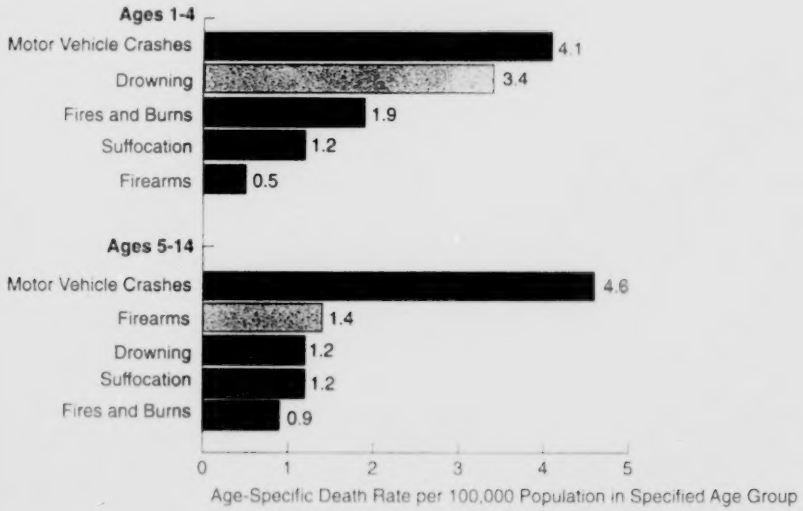
Childhood death rates have declined substantially over the past several decades. Death rates for children ages 1-4 years of age decreased 3.4 percent from 1997, while those aged 5-14 years decreased more than 4.3 percent.

LEADING CAUSES OF DEATH IN CHILDREN AGES 1-14: 1998

Source (II.4): National Center for Health Statistics



CHILDHOOD DEATHS DUE TO EXTERNAL CAUSE, BY CAUSE AND AGE: 1998
Source (II.4): National Center for Health Statistics



CHILDHOOD DEATHS DUE TO INJURY

In 1998, injuries caused the deaths of 2,346 1- to 4-year-old children and 4,074 5- to 14-year-old children. These injuries include homicides, suicides, unintentional deaths, and those of undetermined intent.

Among 1- to 4-year-old children, motor vehicle crashes, drowning, and fire were the leading causes of injury death. Motor vehicle crashes were the leading cause of injury death among 5- to 14-year-old children, followed by firearm deaths. About 47 percent of firearm deaths among 5- to 14-year-old children were homicides.

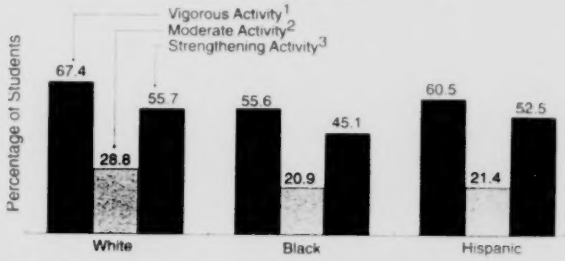
PHYSICAL ACTIVITY AND OVERWEIGHT

Results of the 1999 Youth Risk Behavior Surveillance System Survey (YRBSS) show that nearly two-thirds of students participate regularly in vigorous physical activity and over one quarter regularly participate in moderate physical activity. Furthermore, 54 percent of the students do regular strengthening exercises. Nationwide, 56 percent of students were enrolled in a physical education class, but students in 9th grade were significantly more likely to be enrolled than students in 11th and 12th grades.

The 1999 YRBSS revealed that 30 percent of high school students thought that they were overweight, representing a 10 percent increase from 1997 data. Approximately 43 percent of students were attempting weight loss. Female students were more than twice as likely as male students to be attempting weight loss (59 percent versus 26 percent). Nationwide, 40 percent of all students had dieted either to lose weight or to keep from gaining weight during the 30 days preceding the survey. Nearly 60 percent of students had exercised either to lose weight or to keep from gaining weight.

PERCENTAGE OF HIGH SCHOOL STUDENTS WHO PARTICIPATED IN VIGOROUS, MODERATE, OR STRENGTHENING PHYSICAL ACTIVITY, BY RACE: 1999

Source (II.9): Centers for Disease Control and Prevention



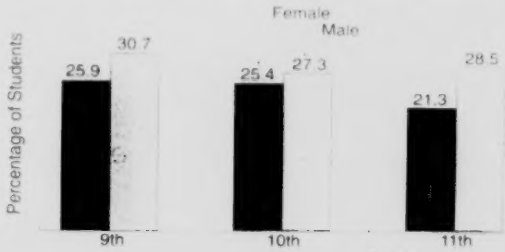
1 Activities that caused sweating and hard breathing for at least 20 minutes > 3 of the preceding 7 days.

2 Walked or bicycled for at least 30 minutes on > 5 of the 7 days preceding the survey.

3 Such as push-ups, sit-ups, or weight lifting on > 3 of the 7 days preceding the survey.

PERCENTAGE OF HIGH SCHOOL STUDENTS WHO PARTICIPATED IN MODERATE PHYSICAL ACTIVITY, BY GRADE: 1999

Source (II.9): Centers for Disease Control and Prevention



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SEXUAL INTERCOURSE

The recent downward trend in the percentage of high school students reporting ever having sexual intercourse was reversed in 1999. In 1997, 48.4 percent of all high school students reported ever having sexual intercourse compared to 49.9 percent in 1999. Black students (71 percent) were most likely to report having had sexual intercourse, followed by Hispanic students (54 percent) and white students (45 percent).

Approximately 51 percent of students in the 12th grade reported having had sexual intercourse during the preceding three months. The prevalence rate of sexual activity increased significantly from grades 9 through 12 among both females (24.0 percent to 53.0 percent) and males (29.1 percent to 48.1 percent). Overall, male students were significantly more likely than female students (19.3 percent versus 13.1 percent) to have had four or more sex partners during their lifetime.

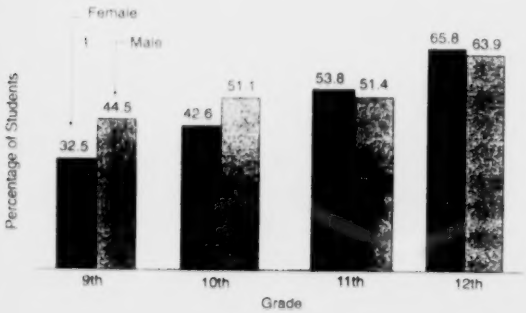
CONDOM USE

In 1999, more than half (58 percent) of sexually active 9th through 12th graders reported condom use during last sexual intercourse. Males were significantly more likely than females to have reported that a condom was used. Black students were more likely than white and Hispanic students to report using a condom during last sexual intercourse.

Sexual activity increased by grade for all students; however, condom use decreased by grade, with 12th-graders being the least likely to use condoms.

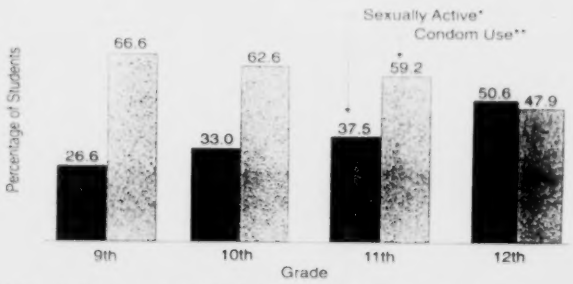
PERCENTAGE OF HIGH SCHOOL STUDENTS WHO HAVE EVER HAD SEXUAL INTERCOURSE, BY GRADE AND GENDER: 1999

Source (II.9): Centers for Disease Control and Prevention



SEXUAL ACTIVITY AND CONDOM USE IN HIGH SCHOOL STUDENTS: 1999

Source (II.9): Centers for Disease Control and Prevention



*Sexual intercourse during the three months prior to the survey.
** Among sexually active students at last sexual intercourse.

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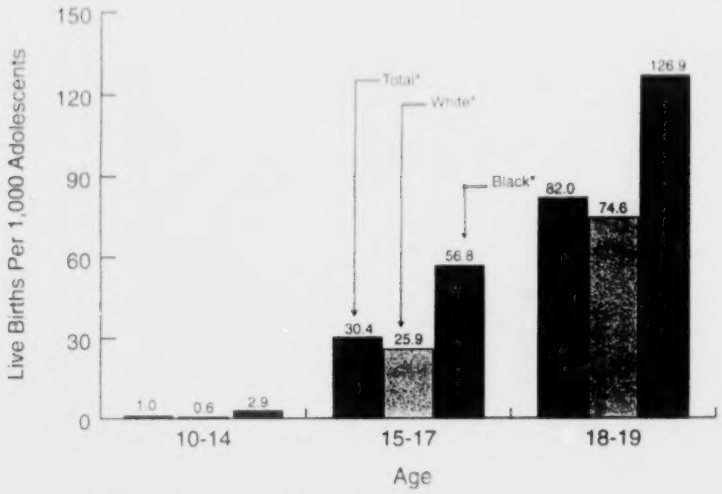
LIVE BIRTHS TO ADOLESCENTS, BY AGE AND RACE OF MOTHER: 1998

Source (II.2): National Center for Health Statistics



* Includes the ethnic classification of Hispanic

ADOLESCENT CHILDBEARING

Birth rates among adolescents of all ages and ethnic groups continue to decline. In 1998, the live birth rate per 1,000 adolescent females was 1.0 for ages 10-14, 30.4 for ages 15-17, and 82.0 for those 18-19 years old. The birth rates among 15- to 19-year-olds in 1998 represent an overall decrease of 18 percent between 1991 and 1998.

In 1998, there were 340,694 live births among white females ages 15-19 and 126,937 births among black teenagers. The birth rates were 45.4, 85.4, and 93.6 for white, black, and Hispanic teenagers respectively. Although the birth rate for black teenagers remains relatively high in comparison to the rate for white teens, the largest decline in birth rates by race between 1991 and 1998 was among black teens. The overall rate of adolescent childbearing among black teens 15-19 years old fell 26 percent to 85.4 per 1,000, the lowest rate ever recorded. The birth rate among Hispanic teens fell the least, 12.3 percent, leaving Hispanic teenagers with the highest adolescent birth rate in the three groups.

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SEXUALLY TRANSMITTED DISEASES

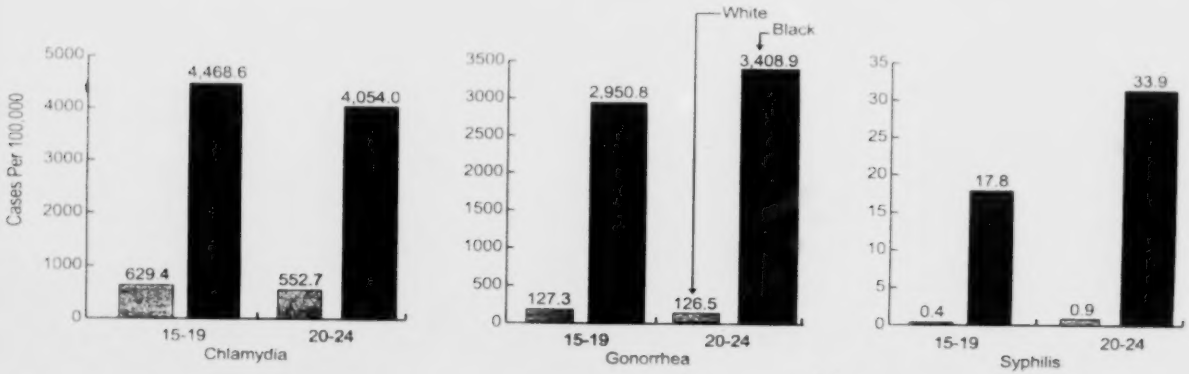
Rates of reportable sexually transmitted diseases (STDs) are particularly high among adolescents (ages 15-19) and young adults (ages 20-24). In these age groups, reported rates of chlamydia, gonorrhea, and syphilis are much higher among black non-Hispanic youth than white non-Hispanics.

The most common STD in adolescents in 1998 was chlamydia, a bacterial infection, with 1,301 cases per 100,000 teens ages 15-19, followed by gonorrhea, with 561 cases per 100,000. Infection rates for both chlamydia and gonorrhea for this age group increased in 1998. Syphilis is much rarer in teens, with only 3.2 cases per 100,000 reported in 1998, down from 4.1 cases in 1997.

Although these conditions are treatable with antibiotics, STDs can have serious health consequences. Active infections can increase the likelihood of contracting HIV, and untreated STDs can lead to pelvic inflammatory disease and infertility in women.

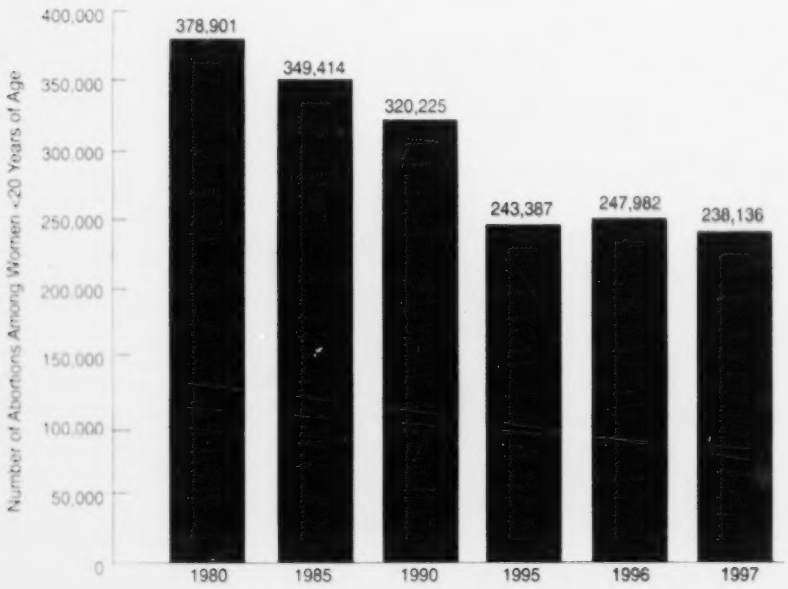
RATES OF SEXUALLY TRANSMITTED DISEASES PER 100,000 ADOLESCENTS BY AGE AND RACE: 1998

Source (H-10): Centers for Disease Control and Prevention



ABORTIONS AMONG WOMEN UNDER 20 YEARS OF AGE: 1980-1997

Source (II.11): Centers for Disease Control and Prevention



ABORTION AMONG ADOLESCENTS

In 1997, there were 493,341 live births among women younger than 20 years of age.

In the same year, a total of 1,184,758 legal abortions were reported to the CDC. Roughly 238,000 abortions—or 20 percent—were to women under the age of 20. The number of reported abortions among females under age 20 decreased steadily from 1980 to 1995. There was a slight increase in 1996, but the number was again reduced in 1997. A decline in unintended pregnancies, reduced access to abortion services, and changes in attitude concerning abortion and childbearing may have contributed to the decline in legal induced abortions during this time period. The number of births among young women also declined, but at a slower rate, over the same period. However, because not all states require reporting of the age of women obtaining legal abortions, complete data on abortions among adolescents are unavailable.

Researchers consistently find four broad factors that predict sexual intercourse at an early age, adolescent pregnancy, and nonmarital childbearing among teenagers: school failure, early behavior problems, poverty, and family problems/family dysfunction.

ADOLESCENT AIDS

As of December 31, 1999, 3,725 cases of AIDS had been reported in adolescents aged 13-19 years. This total includes 312 newly reported cases in 1999.

Forty-nine percent of adolescent AIDS cases were among black non-Hispanics. Thirty-five percent of blacks aged 13-19 were exposed to HIV through heterosexual contact and 24 percent were exposed through male-to-male sexual contact.

Whites comprised 29 percent of the AIDS cases among adolescents. Of these, 57 percent were exposed to HIV primarily through receipt of clotting factor for hemophilia/coagulation disorder or as a result of blood transfusions (however, only 6.4 percent of newly-reported cases in 1999 involved this source of transmission). Nineteen percent of whites aged 13-19 years were exposed to HIV through male-to-male sexual contact.

Note:

1 On January 1, 1993, the AIDS case definition for adults and adolescents aged 13 years and older was expanded to include HIV-infected persons with CD4 counts of less than or equal to 200 cells/μL, or a CD4 percentage of less than or equal to 14, and persons diagnosed with pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.

2 Receipt of Blood/Blood components:

Received clotting factor for hemophilia/coagulation disorder.

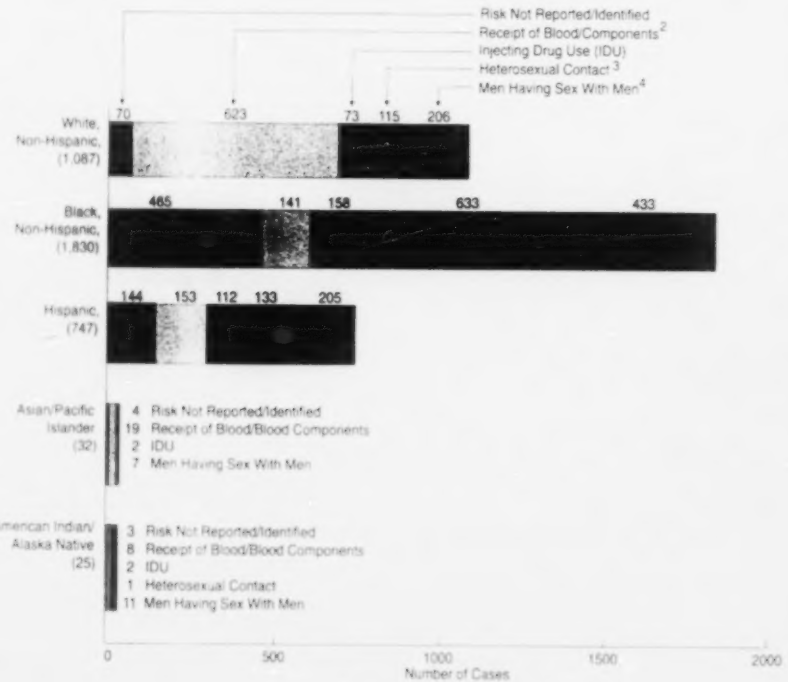
Received blood transfusions, blood components, or tissue.

3 Heterosexual contact includes: sex with an injecting drug user, a person with hemophilia, a transfusion recipient infected with HIV, an HIV infected person, risk not specific, a bisexual male (females only).

4 The category "Men who have sex with men" includes men who have sex with men and inject drugs.

ADOLESCENT AIDS CASES, BY RACE/ETHNICITY AND EXPOSURE CATEGORY FOR AGES 13-19: 1981-1999

Source (II.7): Centers for Disease Control and Prevention



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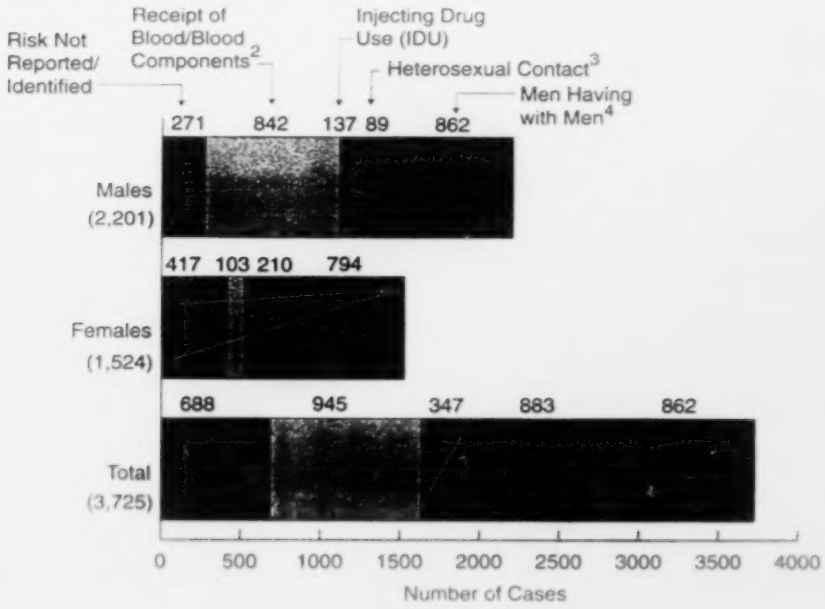
ADOLESCENT AIDS CASES BY GENDER AND EXPOSURE CATEGORY FOR AGES 13-19: 1981-1999

Source (II.7): Centers for Disease Control and Prevention



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ADOLESCENT AIDS

Males comprise 59 percent of the 3,725 AIDS cases ever reported among adolescents aged 13- 19 years. Males aged 13-19 years represent 42 percent of the AIDS cases reported in 1999. Over one third of these new cases were transmitted by men having sex with men. The risk category was not reported, or identified for 41 percent of adolescent male AIDS cases reported in 1999.

Forty-one percent of adolescent AIDS cases ever reported were among females. The proportion of AIDS cases that are new in adolescent females in increasing. In 1999, 58 percent of AIDS cases reported were among adolescent females, up from 50 percent in 1998. Of these, 39 percent acquired HIV infection through heterosexual contact, 7 percent had sex partners who were injecting drug users, and 9 percent were injecting drug users themselves.

Notes:

1 On January 1, 1993, the AIDS case definition for adults and adolescents aged 13 years and older was expanded to include HIV-infected persons with CD4 counts of less than or equal to 200 cells/uL, or a CD4 percentage of less than or equal to 14, and persons diagnosed with pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.

2 Receipt of Blood/Blood components:

Received clotting factor for hemophilia coagulation disorder

Received blood transfusions, blood components, or tissue

3 Heterosexual contact includes sex with: an injecting drug user; a person with hemophilia; a transfusion recipient infected with HIV; an HIV-infected person, risk not specific; a bisexual male (females only).

4 The category "Men who have sex with men" includes men who have sex with men and inject drugs.

YOUNG ADULT AIDS

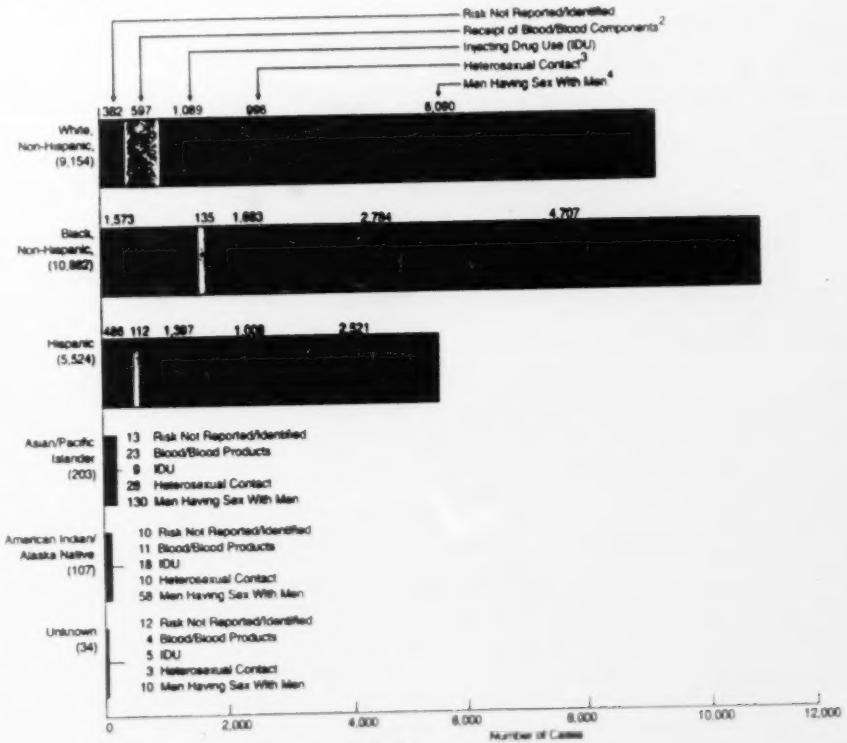
As of December 31, 1999, 25,904 cases of AIDS were reported in young adults aged 20-24 years. This total includes 1,501 newly reported cases in 1999. The number of newly reported cases decreased by nearly 19 percent from 1997 to 1998. However, from 1998 to 1999, the number of newly reported cases was unchanged.

Across all racial/ethnic groups, "men who have sex with men" is the major exposure category associated with AIDS cases in young adults. Young adult women (28 percent of known AIDS cases in this age group) are exposed to HIV primarily through injecting drug use (27 percent) or through having sex with an injecting drug user (21 percent).

Note:
1 On January 1, 1993, the AIDS case definition for adults and adolescents aged 13 years and older was expanded to include HIV-infected persons with CD4 counts of less than or equal to 200 cells/uL, or a CD4 percentage of less than or equal to 14, and persons diagnosed with pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.
2 Receipt of Blood/Blood components:
Received clotting factor for hemophilia coagulation disorder.
Received blood transfusions, blood components, or tissue.
3 Heterosexual contact includes sex with an injecting drug user, a person with hemophilia, a transfusion recipient infected with HIV, an HIV-infected person, risk not specific, a bisexual male (female only).
4 The category "Men who have sex with men" includes men who have sex with men and inject drugs.

YOUNG ADULT AIDS CASES BY RACE/ETHNICITY AND EXPOSURE CATEGORY FOR AGES 20-24: 1981-1999

Source (II.7): Centers for Disease Control and Prevention



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VIOLENCE

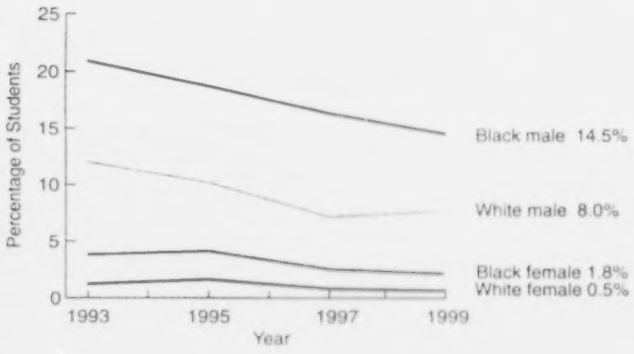
Violence among adolescents has been a longstanding problem in the United States. Firearms (including homicides, suicides, and accidents) were the second leading external cause of death in adolescents ages 15-19 in 1998.

Results of the Youth Risk Behavior Surveillance System (YRBSS) show that in 1999, 17.3 percent of high school students had carried a weapon, such as a gun, knife, or club on one or more days in the last 30 days; nearly 5 percent of students had carried a gun. Boys (28.6 percent) were more than four times as likely as girls (6.0 percent) to carry a weapon. The percentage of high school students who carry weapons has decreased 22 percent since 1993.

Some high school students also reported taking weapons to school. In 1999, 6.9 percent of students had carried a weapon on school property in the last thirty days—a decrease of 42 percent since 1993. However, despite the fact that the percentage of high school students who carry weapons on school property has declined in recent years, the percentage of students who reported being threatened or injured with a weapon on school property in 1999 (7.7 percent) has remained about the same since 1993. In addition, five percent of high school students felt too unsafe to go to school. Girls, younger students, and Black and Hispanic students expressed the most concern for their safety.

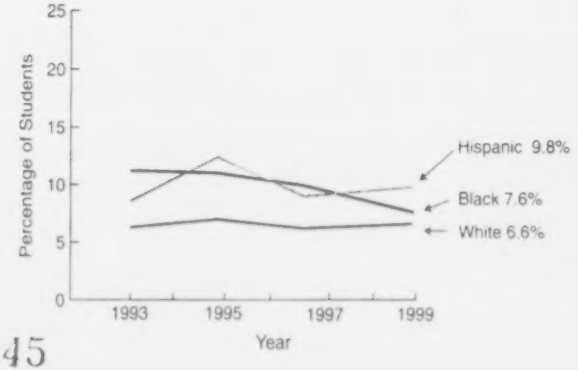
PERCENTAGE OF HIGH SCHOOL STUDENTS WHO CARRIED A GUN IN THE PAST 30 DAYS, BY SEX AND RACE, 1993-1999

Source (II.9): Centers for Disease Control and Prevention



PERCENTAGE OF HIGH SCHOOL STUDENTS WHO WERE THREATENED OR INJURED WITH A WEAPON ON SCHOOL PROPERTY, BY RACE, 1993-1999

Source (II.9): Centers for Disease Control and Prevention



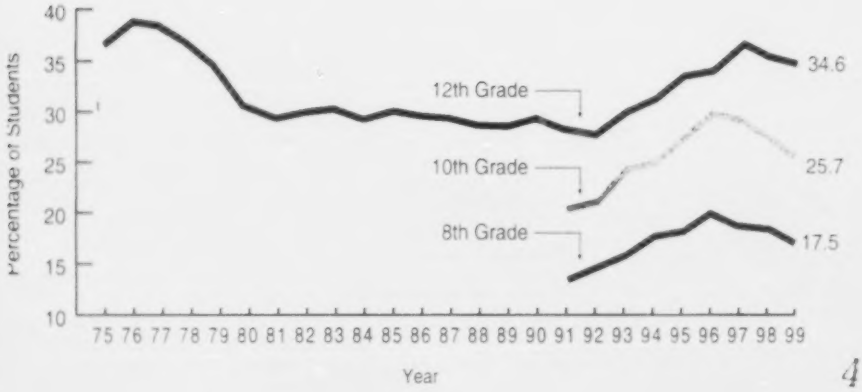
CIGARETTE SMOKING

The Monitoring The Future study conducted by The University of Michigan's Institute for Social Research found a slight, but not statistically significant, decline in cigarette smoking among twelfth- and tenth-graders between 1998 and 1999. Cigarette smoking among eighth graders decreased eight percent, which represents a statistically significant decline. Just under 35 percent of high school seniors reported that they had smoked cigarettes in the 30 days prior to the survey, while almost 18 percent of eighth graders had smoked cigarettes in the same time period.

Smoking among adolescents will have severe, lifelong consequences for this generation, because a large proportion of those who initiate smoking in adolescence will continue to smoke for the rest of their lives.

LONG-TERM TRENDS IN THIRTY-DAY PREVALENCE OF CIGARETTE SMOKING FOR 8TH, 10TH, AND 12-GRADERS: 1975-1999

Source (H.12): The Monitoring the Future Study, University of Michigan



However, despite the recent declines in smoking rates, the prevalence of smoking among teens has increased substantially since 1991. These increases have occurred in virtually every sociodemographic group; among boys and girls, among those bound for college and those not, among respondents in all regions of the country and in rural and urban areas, and among whites, blacks, and Hispanics. The rate of smoking among eighth-grade girls increased 35 percent over this period, and the percentage of black eighth-graders who smoked doubled.

There are, however, some subgroup differences in smoking rates: respondents with no future college plans were more likely to smoke than those who had such plans; 12th grade students were most likely to smoke; and black youth remain substantially less likely to smoke than white youth.

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SUBSTANCE ABUSE

Prevalence and Incidence

Results of the Substance Abuse and Mental Health Services Administration's 1999 National Household Survey on Drug Abuse (NHSDA) show that the percentage of adolescents ages 12-17 who reported using illicit drugs in the month prior to the survey continued to decline. The rate of adolescent use of any illicit drugs declined from 11.4 percent in 1997 to 9.9 percent in 1998 to 9.0 in 1999.

There was no statistically significant change in the reported use of alcohol, marijuana, cocaine, heroin, hallucinogens, or inhalants from 1998 to 1999. However, the proportion of adolescents reporting using marijuana in the past month decreased from 8.3 percent in 1998 to 7.0 in 1999. Marijuana use among adolescents has declined substantially from the highest level recorded in 1979 (14.2 percent); however, use has more than doubled from the lowest recorded rate of 3.4 percent in 1992. Nineteen percent of adolescents age 12-17 are current drinkers. Of these, 7.8 percent reported binge drinking, and 3.6 percent reported heavy alcohol use.

A new component of the 1999 NHSDA revealed that more than 1.5 million Americans under the age of 18 first used marijuana in 1998. The youth rates of marijuana initiation have increased considerably since the early 1990s. Also, one quarter of those who reported smoking, sniffing, or snorting heroin for the first time in 1998 were persons under the age of 18, representing approximately 125,000 youth.

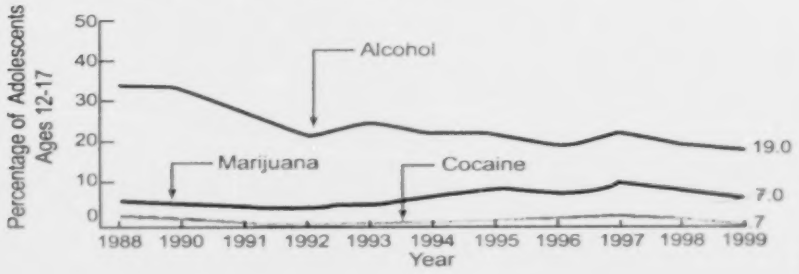
Perception of Risk and Access to Drugs

In 1999, 29 percent of adolescents perceived smoking marijuana to be risky, a decline from 1998, though not a statistically significant change. The percent of adolescents who perceived cocaine use to be risky dropped significantly from 54.3 percent in 1998 to 49.8 percent in 1999.

Fifty-seven percent of the adolescents surveyed in 1999 reported that marijuana was easy to obtain, and approximately 16 percent of respondents reported being approached by someone selling drugs in the month prior to the survey.

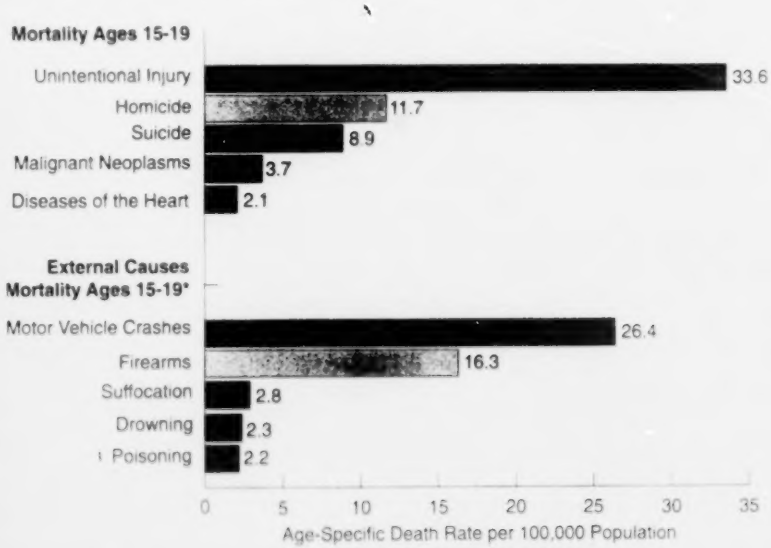
THIRTY-DAY PREVALENCE OF DRUG USE AMONG ADOLESCENTS AGES 12-17: 1988-1999

Source (II.13): National Household Survey on Drug Abuse, SAMHSA



LEADING CAUSES OF DEATH IN ADOLESCENTS AGES 15-19: 1998

Source (II.4): National Center for Health Statistics



Including homicides, suicides, unintentional deaths, and those of undetermined intent.

ADOLESCENT MORTALITY

In 1998, there were 13,788 deaths of adolescents aged 15-19 years. In that age group, injury was the leading cause of death. The 6,590 injury deaths accounted for 48 percent of all deaths among 15- to 19-year-olds in 1998. Homicide and suicide were the next leading causes of death, accounting for 17 and 13 percent, respectively of all deaths among 15- to 19-year-olds. Mortality among teenagers declined substantially between 1960 and the early 1980s. There was a moderate increase in mortality among 15- to 19-year-olds in the mid to late 1980s. The death rate among that age group has decreased almost 19 percent since 1993.

Motor vehicle crashes were the leading cause of injury mortality among 15- to 19-year-olds in 1998, accounting for approximately 78 percent of all injury deaths among teenagers. Firearms were the next leading cause of injury death, representing 23 percent of all injury deaths among 15- to 19-year-olds.

ADOLESCENT DEATHS DUE TO INJURY

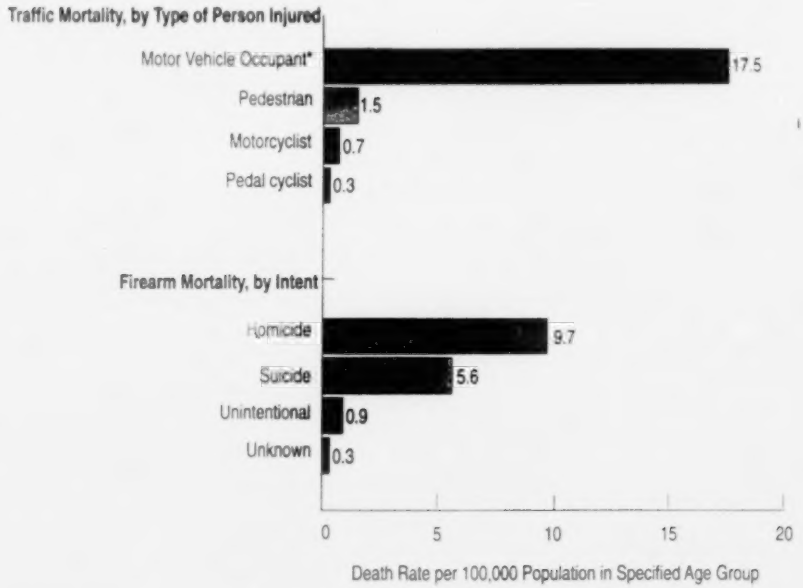
In 1998, motor vehicle crashes caused the deaths of 5,161 15- to 19-year-olds. The vast majority of those killed were in motor vehicles, either as passengers or the driver. Deaths of pedestrians, motorcyclists, and others accounted for the remainder of motor vehicle mortality among teenagers.

Results of CDC's 1999 Youth Risk Behavior Surveillance System (YRBSS) survey revealed that in the 30 days preceding the survey, 16.4 percent of respondents had rarely or never used a safety belt, and 33.1 percent had ridden with a driver who had been drinking alcohol.

In 1998, 3,180 15- to 19-year-olds were killed by firearms. Homicide accounted for 60 percent of firearm deaths among teenagers, 34.2 percent were suicide, and 4.4 percent were considered to be unintentional.

MOTOR VEHICLE CRASHES AND FIREARMS MORTALITY AMONG ADOLESCENTS, AGES 15-19

Source (II.4): National Center for Health Statistics



*Includes the driver.

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HEALTH SERVICES AND UTILIZATION

The availability of, and access to, quality health care directly affects the health of mothers and children, especially those at high risk due to chronic medical conditions or low socioeconomic status. As more mothers and children become enrolled in Medicaid managed care, monitoring quality assurance has become, and will continue to be, increasingly important.

Nearly every state has begun to implement a State Childrens Health Insurance (SCHIP) Program, using new Federal funds that became available for the first time in 1998. This program will help to provide coverage to the approximately 10 million uninsured children in the U.S. An estimated 3 million of those children are eligible for Medicaid, but are not enrolled. Outreach and consumer education are therefore key components of the expansion of health insurance coverage for children.

The following section presents data on the utilization of health services within the maternal and child population. The most current data are summarized by source of payment, type of care, and place of service delivery. Data are presented by age, ethnicity, and income.

HEALTH CARE FINANCING

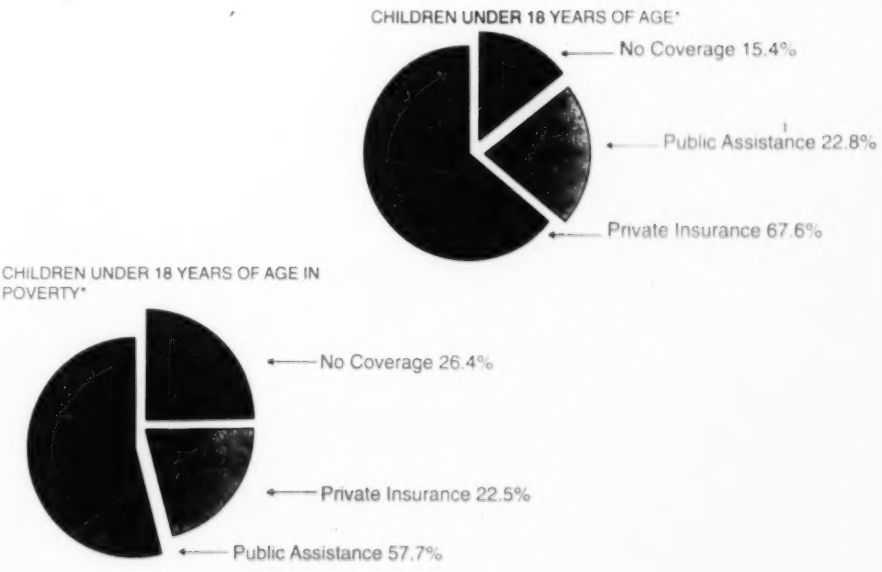
A report from the Employee Benefit Research Institute indicated that 15 percent, or 11.1 million children younger than 18 years of age, had no insurance coverage in 1998; this proportion has been increasing since 1995.

Nearly one quarter of children (22.8 percent) were publicly insured, primarily through Medicaid, and 67.6 percent were covered by private insurance. Most privately insured children (89 percent) received insurance through their parents' employer, but such coverage, when available, is increasingly expensive and requires parental copayments.

Of children younger than 18 whose families lived in poverty, 57.7 percent were publicly insured and 22.5 percent had private coverage. However 26.4 percent of children in poverty had no health coverage in 1998. An estimated 83.1 percent of uninsured children lived in families that had at least one parent who worked part-time or full-time, for all or part of the year. Created in response to the growing number of uninsured children in low-income working families, the State Children's Health Insurance Program (SCHIP) enrolled nearly two million children by the end of 1999.

HEALTH INSURANCE COVERAGE: 1998

Source (III.1): Employee Benefit Research Institute


CHILDREN UNDER 18 YEARS OF AGE*
No Coverage 15.4%
Public Assistance 22.8%
Private Insurance 67.6%
CHILDREN UNDER 18 YEARS OF AGE IN POVERTY*
No Coverage 26.4%
Private Insurance 22.5%
Public Assistance 57.7%

**Details may add to more than 100% because individuals may receive coverage from more than one source.*

VACCINATION COVERAGE LEVELS

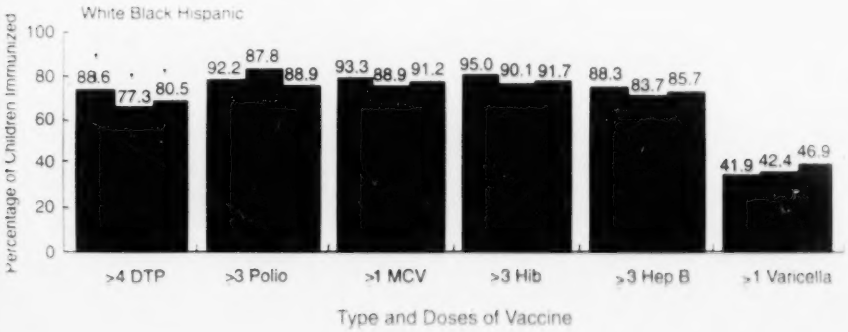
The Year 2010 objective for the complete series of routinely recommended childhood vaccinations is immunization of at least 80 percent of 19 to 35 month-olds with the full series of vaccines. Data released from CDC's 1998 National Immunization Survey revealed the highest immunization coverage ever recorded. Seventy-three percent of children aged 19-35 months received the recommeded vaccines (4 DTaP, 3 polio, 1 MCV, 3 Hib, 3 hepatitis B) in 1998. The greatest progress among children aged 19-35 months was seen in the rate of hepatitis B vaccination, which showed a 28 percent increase, from 68 percent in 1995 to 87 percent in 1998. The FDA-approved varicella (chicken pox) vaccine, which was added to the schedule in 1996, was administered to 43 percent of children aged 19-35 months in 1998.

However, approximately 1 million children still need one or more of the recommended doses of a series of vaccine to be fully protected. Coverage varies by race and ethnicity and state and urban areas. With the exception of the new varicella vaccine, a greater proportion of white children aged 19-35 months receive the recommended immunizations compared to black and Hispanic children.

In January 2000, CDC published an updated immunization schedule (see facing page), which includes several changes. A new vaccine to protect children from rotavirus, the most common cause of severe diarrhea, was licensed in August 1998 and suspended in July 1999 due to reports of bowel obstructions in some infants. In October 1999 the CDC recommended that the use of rotavirus in the United States be discontinued. The new immunization schedule also recommends the use of inactivated poliovirus vaccines for all doses of the polio vaccine, and the use of acellular pertussis vaccines for all doses of the pertussis vaccine. Also, a new vaccine for Hepatitis A was added to the schedule for states and regions where incidence of this disease is especially high.

ESTIMATED VACCINATION COVERAGE AMONG CHILDREN AGED 19-35 MONTHS BY RACE/ETHNICITY: 1998

Source (III.2): Centers for Disease Control and Prevention



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RECOMMENDED CHILDHOOD IMMUNIZATION SCHEDULE, UNITED STATES, JANUARY–DECEMBER 2000

VACCINE / AGE	Routinely recommended age for vaccination											
	Birth	1 mo.	2 mos.	4 mos.	6 mos.	12 mos.	15 mos.	18 mos.	24 mos.	4-6 yrs.	11-12 yrs.	14-16 yrs.
Hepatitis B[2]		Hep B										
			Hep B				Hep B				Hep B	
Diphtheria, Tetanus, Pertussis[3]			DTaP	DTaP	DTaP		DTaP[3]			DTaP	Td	
H. influenzae type b[4]			Hib	Hib	Hib		Hib					
Polio[5]			IPV	IPV			IPV[5]			IPV[5]		
Measles, Mumps, Rubella[6]							MMR			MMR[6]	MMR[6]	
Varicella[7]							Var				Var[7]	
Hepatitis A[8]									Hep A[8] in selected areas			

Vaccines[1] are listed under routinely recommended ages. **Bars** indicate range of recommended ages for immunization. Any dose not given at the recommended age should be given as a "catch-up" immunization at any subsequent visit when indicated and feasible. **Ovals** indicate vaccines to be given if previously recommended doses were missed or given earlier than the recommended minimum age.

On October 22, 1999, the Advisory Committee on Immunization Practices (ACIP) recommended that Rotashield (RRV-TV), the only U.S. licensed rotavirus vaccine, no longer be used in the United States (MMWR, Volume 48, Number 43, Nov. 5, 1999). Parents should be reassured that those children who received rotavirus vaccine before July are not at increased risk for intussusception now.

[1] This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines as of 11/1/99. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and its other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations.

[2] Infants born to HBsAg-negative mothers should receive the 1st dose of hepatitis B (Hep B) vaccine by age 2 months. The 2nd dose should be at least one month after the 1st dose. The 3rd dose should be administered at least 4 months after the 1st dose and at least 2 months after the 2nd dose, but not before 6 months of age for infants.

Infants born to HBsAg-positive mothers should receive hepatitis B vaccine and 0.5 mL hepatitis B immune globulin (HBIG) within 12 hours of birth at separate sites. The 2nd dose is recommended at 1-2 months of age and the 3rd dose at 6 months of age.

Infants born to mothers whose HBsAG status is unknown should receive hepatitis B vaccine within 12 hours of birth. Maternal blood should be drawn at the time of delivery to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than 1 week of age).

All children and adolescents (through 18 years of age) who have not been immunized against hepatitis B may begin the series during any visit. Special efforts should be made to immunize children who were born in or whose parents were born in areas of the world with moderate or high endemicity of hepatitis B virus infection.

[3] The 4th dose of DTaP (diphtheria and tetanus toxoids and acellular pertussis vaccine) may be administered as early as 12 months of age, provided 6 months have elapsed since the 3rd dose and the child is unlikely to return at age 15-18 months. Td (tetanus and diphtheria toxoids) is recommended at 11-12 years of age if at least 5 years have elapsed since the last dose of DTP, DTaP or DT. Subsequent routine Td boosters are recommended every 10 years.

[4] Three Haemophilus influenzae type b (Hib) conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB or ComVax [Merck]) is administered at 2 and 4 months of age, a dose at 6 months is not required. Because clinical studies in infants have demonstrated that using some combination products may reduce a lower immune response to the Hib vaccine component, DTaP/Hib combination products should not be used for primary immunization in infants at 2, 4 or 6 months of age, unless FDA-approved for these ages.

[5] To eliminate the risk of vaccine-associated paralytic polio (VAPP), an all-IPV schedule is now recommended for routine childhood polio vaccination in the United States. All children should receive four doses of IPV at 2 months, 4 months, 6-18 months, and 4-6 years. OPV (if available) may be used only for the following special circumstances:

1. Mass vaccination campaigns to control outbreaks of paralytic polio.

2. Unvaccinated children who will be traveling in <4 weeks to areas where polio is endemic or epidemic.

3. Children of parents who do not accept the recommended number of vaccine injections. These children may receive OPV only for the third or fourth dose or both, in this situation, health-care providers should administer OPV only after discussing the risk for VAPP with parents or caregivers.

4. During the transition to an all-IPV schedule, recommendations for the use of remaining OPV supplies in physicians' offices and clinics have been issued by the American Academy of Pediatrics (see Pediatrics, December 1999).

[6] The 2nd dose of measles, mumps, and rubella (MMR) vaccine is recommended routinely at 4-6 years of age but may be administered during any visit, provided at least 4 weeks have elapsed since receipt of the 1st dose and that both doses are administered beginning at or after 12 months of age. Those who have not previously received the second dose should complete the schedule by the 11-12 year old visit.

[7] Varicella (Var) vaccine is recommended at any visit on or after the first birthday for susceptible children, i.e. those who lack a reliable history of chickenpox (as judged by a health care provider) and who have not been immunized. Susceptible persons 13 years of age or older should receive 2 doses, given at least 4 weeks apart.

[8] Hepatitis A (Hep A) is shaded to indicate it is recommended for in selected states and/or regions; consult your local public health authority. (Also see MMWR Oct. 01, 1999/48(RR12); 1-37).

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DENTAL CARE

Access to oral health care is a significant problem for low-income children. The 1997 National Survey of America's Families conducted by the Urban Institute found that almost one in ten low-income children had an unmet need for dental care. Nearly thirty percent of low-income children had not been to the dentist in the last year, and almost 60 percent had not received the two dental checkups in the last year recommended by the American Academy of Pediatrics.

Utilization of dental care among low-income children varies by a number of demographic characteristics. Low-income children who have not had a dental visit in the last year are more likely to be younger, uninsured, in fair or poor health, Hispanic, and born outside the United States. These children are also more likely to have parents who did not graduate from high school or earn a GED, and to live in the southern or western states.

Although many dental problems can be prevented with regular screening and preventive services, these services are not always available to those children who need them most. In Federal Fiscal Year 1997, only one in five children eligible for dental services under the Medicaid Early and Preventive Screening, Diagnosis, and Treatment (EPSDT) program received a preventive dental service.

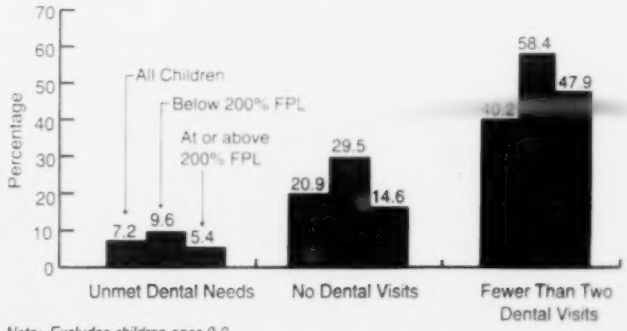
Under the new State Children's Health Insurance Program (SCHIP), 48 States and the District of Columbia provide dental coverage or children with family incomes below 200 percent of the Federal Poverty Level.

PERCENTAGE OF CHILDREN RECEIVING AN EPSDT PREVENTIVE DENTAL SERVICE: 1988-1997

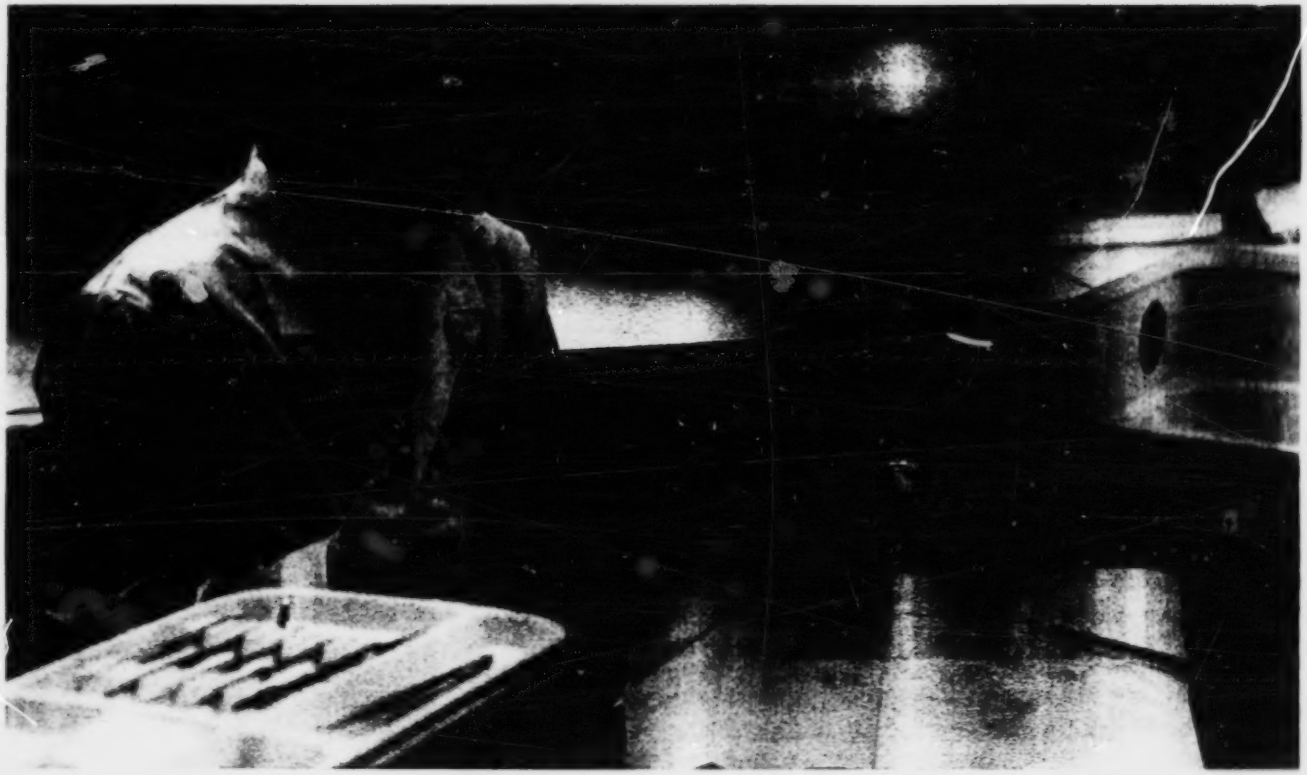
Source (III.4): Health Care Financing Administration

PERCENTAGE OF CHILDREN WITH DENTAL CARE NEEDS AND THOSE RECEIVING DENTAL CARE IN THE LAST 12 MONTHS BY INCOME: 1997

Source (III.5): National Survey of America's Families, Urban Institute

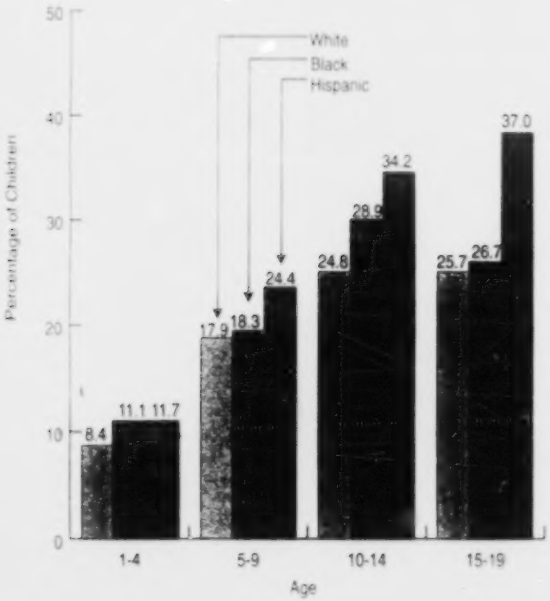


Note: Excludes children ages 0-2.



PERCENTAGE OF CHILDREN WITH NO PHYSICIAN VISITS IN THE PAST YEAR, BY AGE AND RACE/ETHNICITY: 1996

Source: [illegible] National Center for Health Statistics



PHYSICIAN VISITS

In 1996, approximately 9 percent of preschoolers and 18 percent of children ages 5-9 had not been seen by a physician in the past year. Experts recommend that children see a doctor eight times in their first year, three times in their second year, and once a year until age six. In all age groups, a higher percentage of black and Hispanic children than white children had not been seen by a physician in the past year.

During 1996, 8.4 percent of white, 11.1 percent of black, and 11.7 percent of Hispanic-origin children ages 1-4 were not seen by a physician.

PLACE OF PHYSICIAN CONTACT

Among children who saw a physician in the past year, children younger than 5 years old averaged nearly twice as many physician contacts as school-aged children.

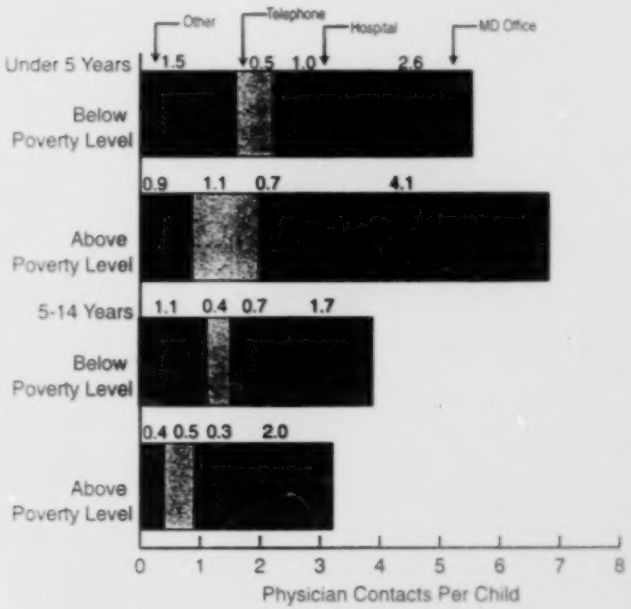
Children under 5 years of age whose family income was above the poverty level used more physician services than children in poverty.

Children in poverty were more likely to see physicians in hospitals and places other than physicians' offices than children above poverty.

From 1995 to 1996, the number of physician contacts per child in a physician's office for children in poverty, decreased for children under 5 and increased for children aged 5-14.

PLACE OF PHYSICIAN CONTACT BY AGE AND POVERTY STATUS: 1996

Source (III.6): National Center for Health Statistics



SERVICE USE BY CHILDREN WITH CHRONIC CONDITIONS

Physician Use

In 1996, children who were limited in their activities* had three times as many physician contacts as children without chronic conditions.** The number of physician contacts per person for children without activity limitations remained stable from 1995 to 1996, while it increased for children under age 5 with activity limitations and decreased for teens and young adults with limitations.

Hospital Use

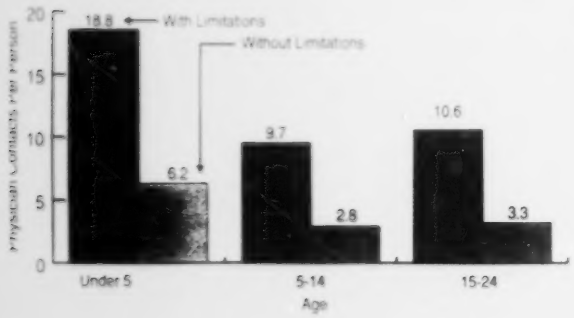
Children with activity limitations spend about 6 times as many days in the hospital as children without activity limitations.

*Limitation of activity is defined as the inability to participate in ordinary play for children less than 5 years old, or the inability to attend school for children 5 to 17 years old.

**Chronic conditions persist for more than three months. Conditions that are considered chronic regardless of their time of onset include diabetes and heart condition.

PHYSICIAN UTILIZATION BY CHILDREN WITH CHRONIC ACTIVITY LIMITATIONS, BY AGE: 1996

Source (III.6): National Center for Health Statistics



HOSPITAL UTILIZATION BY CHILDREN WITH CHRONIC ACTIVITY LIMITATIONS, BY AGE: 1996 (EXCLUDING DELIVERIES)

Source (III.6): National Center for Health Statistics,

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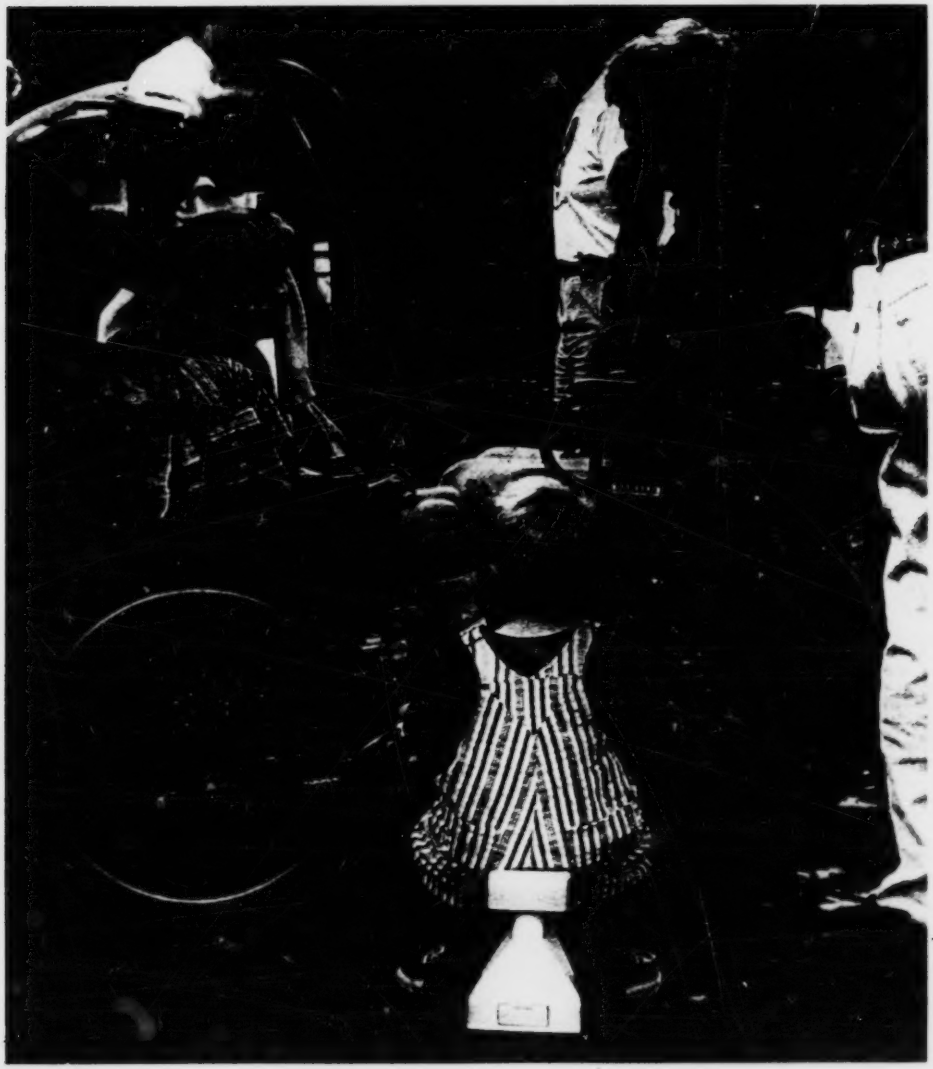
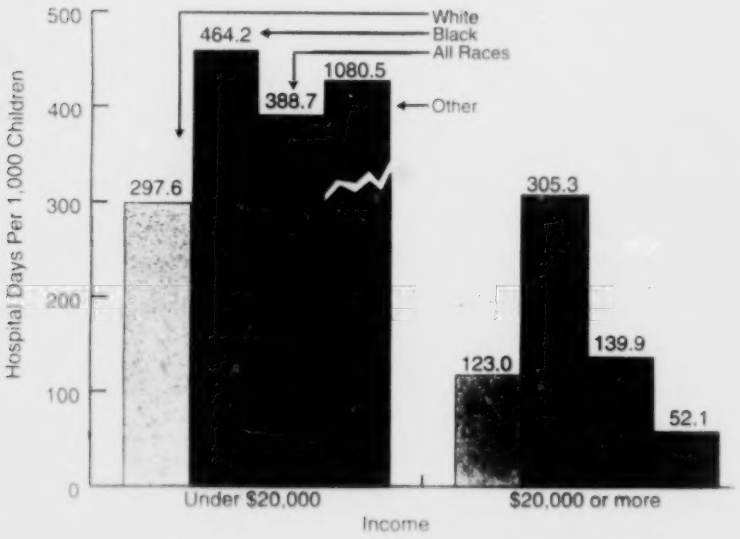


HOSPITAL UTILIZATION BY INCOME AND RACE: 1996

Source (III.6): National Center for Health Statistics



HOSPITAL UTILIZATION

In 1996, children younger than age 18 in families with incomes less than $20,000 averaged 2.8 times as many hospital days per 1,000 children as children in higher-income families.

For non-white, low-income children, and for black children with higher incomes, rates of hospital use increased from 1995-1996. For children with family incomes above $20,000, rates decreased for all racial groups except blacks.

**Other includes: Indian, Eskimo, Aleut, Chinese, Filipino, Hawaiian, Korean, Vietnamese, Japanese, Asian Indian, Samoan, Guamanian, Other Asia Pacific Islanders, Other Race, Multiple Race, Unknown*

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PRENATAL CARE

Early Prenatal Care

The proportion of mothers beginning prenatal care in the first trimester of pregnancy increased for the ninth consecutive year, rising from 82.5 percent in 1997 to 82.8 percent in 1998.

However, the racial disparity in early entry into prenatal care persists. In 1998, 84.8 percent of white mothers, as compared with 73.3 percent of black mothers, received early prenatal care.

Women younger than 20 are much less likely than older women to receive early prenatal care.

Late or No Prenatal Care

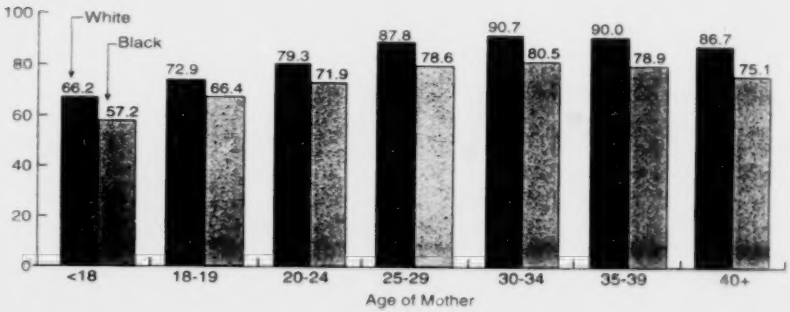
Every year from 1983 to 1991, 6 percent of all of infants were born to mothers who initiated care during the third trimester or received no prenatal care. However, that figure decreased to 4 percent in 1996 and remains at that level in 1998.

Regardless of age, black women are less likely to receive prenatal care than are white women.

Risk factors for not receiving prenatal care include being less than 18 years of age, being unmarried, low educational attainment, and minority group status.

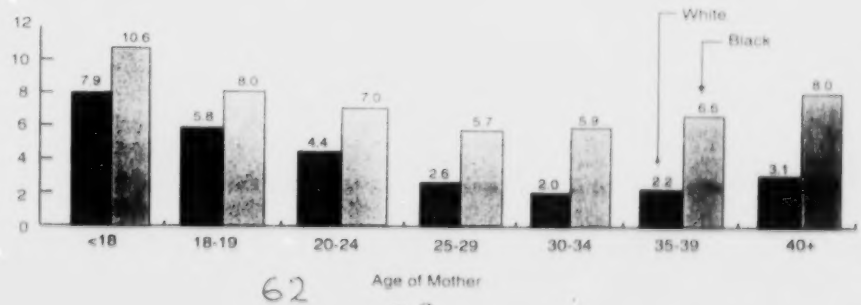
PERCENTAGE OF BIRTHS TO WOMEN WITH EARLY PRENATAL CARE, BY AGE AND RACE OF MOTHER: 1998

Source (III.7): National Center for Health Statistics



PERCENTAGE OF BIRTHS TO WOMEN WITH LATE OR NO PRENATAL CARE, BY AGE AND RACE OF MOTHER: 1998

Source (III.7): National Center for Health Statistics



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STATE DATA

While the indicators presented in the previous sections of this book are representative of the U.S. as a whole, the next section presents state-level health status indicators, data on infant and neonatal mortality, low birth weight, early prenatal care, births to women under 18, health care financing for children, Medicaid enrollment and expenditures, and SCHIP enrollment.

The following pages reveal stark disparities in the health status of children living in different states. In 1998, the national infant mortality rate (deaths per 1,000 live births) was 7.2. Among the 50 states, New Hampshire had the lowest rate (4.4), while the District of Columbia had the highest rate (12.5). Women living in Alabama, Louisiana, Mississippi, South Carolina, Tennessee, and the District of Columbia were more likely to give birth to low birth weight babies (less than 2,500 grams or 5.5 pounds) than women in other regions of the country.

Poverty in the U.S. has continued to rise steadily during the last three decades. Title XIX of the Social Security Act (Medicaid) assures that children living in poverty receive adequate health care services. In 1998, the District of Columbia had the greatest proportion of children with health care financed via Medicaid (42.4 percent) whereas Nevada had the smallest proportion (7.1 percent). The national average was 19.9 percent. Through the State Children's Health Insurance Program, many more children now have the opportunity to receive much-needed health care services. States may implement this program through a Medicaid expansion, a separate program, or a combination of the two. Connecticut, Missouri, New Hampshire, New Jersey, Rhode Island, and Vermont have the highest SCHIP upper eligibility limits at 300 percent of the Federal Poverty Level and higher. Poverty affects living conditions and access to health care and nutrition, all of which contribute to health status.

The challenge to health care providers and policy-makers continues to be eliminating the disparities among states while improving the health status of children throughout the entire Nation.

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PERCENTAGE OF INFANTS BORN AT LOW BIRTH WEIGHT, WOMEN RECEIVING FIRST TRIMESTER PRENATAL CARE, AND BIRTHS TO WOMEN UNDER 18, BY RACE OF MOTHER AND STATE: 1998

Source (IV1): National Center for Health Statistics

State	Percentage at Low Birth Weight			Percentage with Early Prenatal Care			Percentage of Births to Women < 18			
	All***	White	Black	All***	White	Black	All***	White	Black	Hispanic
UNITED STATES†	**7.6**	**6.5**	**13.0**	**82.8**	**84.8**	**73.3**	**4.6**	**3.9**	**8.9**	**6.9**
ALABAMA	9.3	7.3	13.3	82.4	88.3	70.1	6.5	4.6	10.5	6.2
ALASKA	6.0	5.6	10.5	81.4	83.5	82.3	4.0	2.8	5.0	5.2
ARIZONA	6.8	6.6	12.2	75.1	76.0	73.5	6.0	5.8	9.0	8.9
ARKANSAS	8.9	7.5	13.9	77.8	80.7	67.6	6.7	5.1	12.5	5.9
CALIFORNIA	6.2	5.7	11.6	82.4	82.4	79.5	4.4	4.5	6.4	6.2
COLORADO	8.6	8.3	13.3	82.2	82.7	75.9	4.5	4.3	8.3	9.2
CONNECTICUT	7.8	7.0	13.3	88.0	89.3	79.0	3.1	2.6	7.5	9.3
DELAWARE	8.4	6.2	14.8	83.4	86.4	74.2	5.1	3.3	10.5	7.0
DC	13.1	5.9	15.8	72.0	84.8	66.9	6.5	2.2	8.3	5.1
FLORIDA	8.1	6.8	12.2	83.6	86.9	72.8	5.1	3.9	9.2	5.0
GEORGIA	8.5	6.4	12.7	86.4	90.0	79.4	5.8	4.2	9.0	5.7
HAWAII	7.5	6.2	10.7	85.4	90.2	91.5	4.1	1.2	*	9.1
IDAHO	6.0	6.0	*	78.7	79.1	69.1	4.2	4.1	*	8.7
ILLINOIS	8.0	6.4	14.2	82.7	85.7	70.1	4.8	3.3	11.5	6.1
INDIANA	7.9	7.2	13.5	79.9	81.6	65.3	4.6	4.0	10.3	7.1
IOWA	6.4	6.2	12.8	87.3	87.9	74.8	3.4	3.2	9.7	6.9
KANSAS	7.0	6.5	13.0	85.8	86.7	76.1	4.1	3.7	9.3	7.2
KENTUCKY	8.1	7.6	13.5	86.4	87.3	78.0	5.2	4.9	9.3	4.9
LOUISIANA	10.1	7.0	14.6	82.2	89.4	72.1	7.0	4.1	11.1	3.5
MAINE	5.8	5.8	*	88.9	89.1	85.6	3.0	2.9	*	*
MARYLAND	8.7	6.4	13.0	87.8	91.5	80.3	4.0	2.3	7.5	4.1
MASSACHUSETTS	6.9	6.5	10.2	89.5	90.9	80.1	2.6	2.3	5.7	8.8
MICHIGAN	7.8	6.4	13.8	84.3	87.1	71.1	4.1	3.1	8.5	7.0
MINNESOTA	5.8	5.4	11.0	84.5	87.1	66.7	2.9	2.2	8.8	7.5
MISSISSIPPI	10.1	7.2	13.7	80.6	89.3	70.2	8.1	4.8	12.0	5.5
MISSOURI	7.8	6.7	14.0	86.1	88.2	74.5	4.8	3.9	10.0	6.3
MONTANA	7.0	6.9	*	82.3	84.8	77.3	4.1	3.3	*	8.9
NEBRASKA	6.5	6.2	12.2	83.9	84.9	71.0	3.6	3.1	10.3	6.8
NEVADA	7.6	6.9	13.3	74.6	75.3	66.3	4.8	4.6	8.4	6.7
NEW HAMPSHIRE	5.7	5.6	*	89.7	89.8	76.9	2.4	2.4	*	*
NEW JERSEY	8.0	6.7	13.3	81.6	85.5	65.1	2.8	2.0	7.2	5.6
NEW MEXICO	7.6	7.7	11.4	67.6	69.1	58.5	7.3	7.3[1]	10.4	10.0
NEW YORK	7.8	6.7	11.9	81.2	84.4	70.8	3.2	2.7	5.6	5.7
NORTH CAROLINA	8.8	7.0	13.9	84.5	88.1	75.2	5.2	3.8	9.1	6.0
NORTH DAKOTA	6.5	6.5	*	85.6	87.3	78.8	3.2	2.4	*	*
OHIO	7.7	6.7	13.2	85.5	87.6	73.3	4.5	3.5	10.0	7.4
OKLAHOMA	7.2	6.6	12.5	78.6	80.7	69.7	5.8	4.9	9.2	8.9
OREGON	5.4	5.2	9.8	80.2	80.4	79.4	4.4	4.3	8.8	7.0
PENNSYLVANIA	7.6	6.6	13.5	84.8	87.3	70.8	3.8	2.9	9.5	10.7
RHODE ISLAND	7.6	7.1	11.4	89.7	90.9	79.3	3.9	3.5	6.6	7.9
SOUTH CAROLINA	9.5	7.1	14.0	81.4	87.2	71.0	6.4	4.4	10.2	4.9
SOUTH DAKOTA	5.8	5.7	*	82.7	86.6	75.3	3.7	2.6	*	*
TENNESSEE	9.1	7.6	14.3	84.1	87.3	72.7	5.7	4.5	10.4	5.8
TEXAS	7.4	6.7	12.6	79.3	79.6	75.7	6.4	6.2	8.9	8.5
UTAH	6.7	6.6	14.9	82.1	82.9	64.7	3.1	3.1	7.5	7.9
VERMONT	6.5	6.5	*	87.4	87.5	*	2.3	2.3	*	*
VIRGINIA	7.9	6.4	12.7	85.2	88.8	74.4	3.7	2.5	7.7	3.5
WASHINGTON	5.7	5.4	10.1	83.0	83.6	77.1	3.8	3.6	6.4	7.1
WEST VIRGINIA	8.0	7.8	13.4	83.7	84.2	70.2	5.0	4.9	8.7	*
WISCONSIN	6.5	5.7	13.6	84.3	87.0	67.5	3.7	2.5	12.3	7.8
WYOMING	8.9	8.8	*	81.3	82.2	67.3	4.8	4.6	*	8.6

** figure does not meet standards of reliability or precision*

† excludes data for the territories

**** includes races other than white and black*

MEDICAID ENROLLEES, EXPENDITURES, AND REPORTED EPSDT UTILIZATION FOR CHILDREN UNDER AGE 21: FY 1998

Source (IV.2): American Academy of Pediatrics

State	Medicaid Enrollees	Per Enrollee Expenditures*	% Medicaid Enrollees Who Used EPSDT Services **
UNITED STATES	**22,331,022**	**$1,449**	**26.1**
ALABAMA	364,832	$750	33.1
ALASKA	52,428	$2,361	2.0
ARIZONA	412,367	$1,606	58.3
ARKANSAS	236,727	$2,193	41.4
CALIFORNIA	3,438,056	$1,079	17.5
COLORADO	200,408	$1,822	18.6
CONNECTICUT	213,695	$1,608	2.4
DELAWARE	58,513	$2,138	2.4
DC	76,525	$1,851	0.9
FLORIDA	1,137,381	$1,194	22.5
GEORGIA	746,845	$1,133	36.9
HAWAII	87,249	$1,325	0.0
IDAHO	74,589	$1,346	27.9
ILLINOIS	1,045,873	$1,521	45.4
INDIANA	371,973	$1,428	23.5
IOWA	172,238	$1,914	34.3
KANSAS	144,723	$1,402	51.2
KENTUCKY	335,619	$1,938	11.4
LOUISIANA	430,065	$1,466	64.8
MAINE	95,689	$1,831	47.7
MARYLAND	338,566	$1,871	13.1
MASSACHUSETTS	564,560	$1,421	5.9
MICHIGAN	781,009	$1,081	19.7
MINNESOTA	333,186	$2,017	5.0
MISSISSIPPI	298,274	$1,235	44.6
MISSOURI	467,499	$1,182	14.8
MONTANA	51,466	$1,762	20.5
NEBRASKA	132,063	$1,408	NA
NEVADA	80,747	$2,042	33.6
NEW HAMPSHIRE	58,861	$2,179	27.4
NEW JERSEY	460,440	$1,731	2.4
NEW MEXICO	231,378	$1,662	7.7
NEW YORK	1,621,869	$2,571	31.1
NORTH CAROLINA	674,006	$1,605	57.2
NORTH DAKOTA	32,657	$1,817	0.1
OHIO	796,056	$1,506	15.7
OKLAHOMA	NA	NA	NA
OREGON	255,894	$1,475	0.0
PENNSYLVANIA	882,877	$1,732	18.2
RHODE ISLAND	77,751	$2,046	4.5
SOUTH CAROLINA	369,983	$1,371	29.2
SOUTH DAKOTA	52,925	$1,871	25.8
TENNESSEE	669,063	$987	0.0
TEXAS	1,689,961	$1,210	61.7
UTAH	126,290	$1,544	4.0
VERMONT	62,282	$1,412	30.8
VIRGINIA	412,235	$1,238	20.8
WASHINGTON	572,927	$840	5.6
WEST VIRGINIA	209,341	$1,223	29.0
WISCONSIN	299,364	$1,582	10.0
WYOMING	31,697	$1,502	25.7

**Does not include Disproportionate Share Hospital Payments. **Percents smaller than 0.05 are rounded to zero. Under-reporting of Early Periodic Screening Diagnosis and Treatment (EPSDT) services is known to be a problem in some states due to complexities in the reporting process. "NA" Data unavailable. Per child enrollee expenditures was $1,158 for Oklahoma in FY 1996. States with missing FY 1998 data are not included in computation of the US average.*

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STATE CHILDREN'S HEALTH INSURANCE PROGAM (SCHIP) AGGREGATE ENROLLMENT STATISTICS: FY 1999

Source (IV.3): Health Care Financing Administration

State	Type of SCHIP Program	Date Implemented	Upper* Eligibility	Total SCHIP Enrollment
ALABAMA	COMBO	02/01/98	200%	38,980
ALASKA	MEDICAID	03/01/99	200%	8,033
ARIZONA	SEPARATE	11/01/98	200%	26,807
ARKANSAS	MEDICAID	10/01/98	100%	913
CALIFORNIA	COMBO	03/01/98	250%	222,351
COLORADO	SEPARATE	04/22/98	185%	24,116
CONNECTICUT	COMBO	07/01/98	300%	9,912
DELAWARE	SEPARATE	02/01/99	200%	2,433
DC	MEDICAID	10/01/98	200%	3,029
FLORIDA	COMBO	04/01/98	200%	154,594
GEORGIA	SEPARATE	11/01/98	200%	47,581
HAWAII	MEDICAID	07/01/00	185%	N/I
IDAHO	MEDICAID	10/01/97	150%	8,482
ILLINOIS	MEDICAID	01/05/98	133%	42,699
INDIANA+	COMBO	10/01/97	200%	31,246
IOWA	COMBO	07/01/98	185%	9,795
KANSAS	SEPARATE	01/01/99	200%	14,443
KENTUCKY+**	COMBO	07/01/98	200%	18,579
LOUISIANA	MEDICAID	11/01/98	150%	21,580
MAINE	COMBO	07/01/98	185%	13,657
MARYLAND	MEDICAID	07/01/98	200%	18,072
MASSACHUSETTS	COMBO	10/01/97	200%	67,852
MICHIGAN	COMBO	05/01/98	200%	26,652
MINNESOTA**	MEDICAID	10/01/98	280%	21
MISSISSIPPI+	COMBO	07/01/98	200%	13,218
MISSOURI	MEDICAID	09/01/98	300%	49,529
MONTANA	SEPARATE	01/01/99	150%	1,019
NEBRASKA	MEDICAID	05/01/98	185%	9,713
NEVADA	SEPARATE	10/01/98	200%	7,802
NEW HAMPSHIRE	COMBO	05/01/98	300%	4,554
NEW JERSEY	COMBO	03/01/98	350%	75,652
NEW MEXICO**	MEDICAID	03/31/99	235%	4,500
NEW YORK	COMBO	04/15/98	192%	521,301
NORTH CAROLINA**	SEPARATE	10/01/98	200%	57,300
NORTH DAKOTA+	COMBO	10/01/98	140%	266
OHIO	MEDICAID	01/01/98	150%	83,688
OKLAHOMA**	MEDICAID	12/01/97	185%	40,196
OREGON	SEPARATE	07/01/98	170%	27,285
PENNSYLVANIA	SEPARATE	05/28/98	200%	81,758
RHODE ISLAND	MEDICAID	10/01/97	300%	7,288
SOUTH CAROLINA	MEDICAID	10/01/97	150%	45,737
SOUTH DAKOTA	MEDICAID	07/01/98	140%	3,191
TENNESSEE**	MEDICAID	10/01/97	100%	9,732
TEXAS+	COMBO	07/01/98	200%	90,878
UTAH	SEPARATE	08/03/98	200%	13,040
VERMONT**	SEPARATE	10/01/98	300%	2,055
VIRGINIA	SEPARATE	10/22/98	185%	16,895
WASHINGTON	SEPARATE	02/01/00	250%	N/I
WEST VIRGINIA	COMBO	07/01/98	150%	7,957
WISCONSIN	MEDICAID	04/01/99	185%	12,949
WYOMING	SEPARATE	12/01/99	133%	N/I

**Reflects upper eligibility level of SCHIP plans and amendments approved as of January 1, 2000 as a percentage of the Federal Poverty Level.*

***State reported SCHIP enrollment is estimated.*

+Separate program not implemented as of September 30, 1999.

N/I not implemented as of September 30, 1999.

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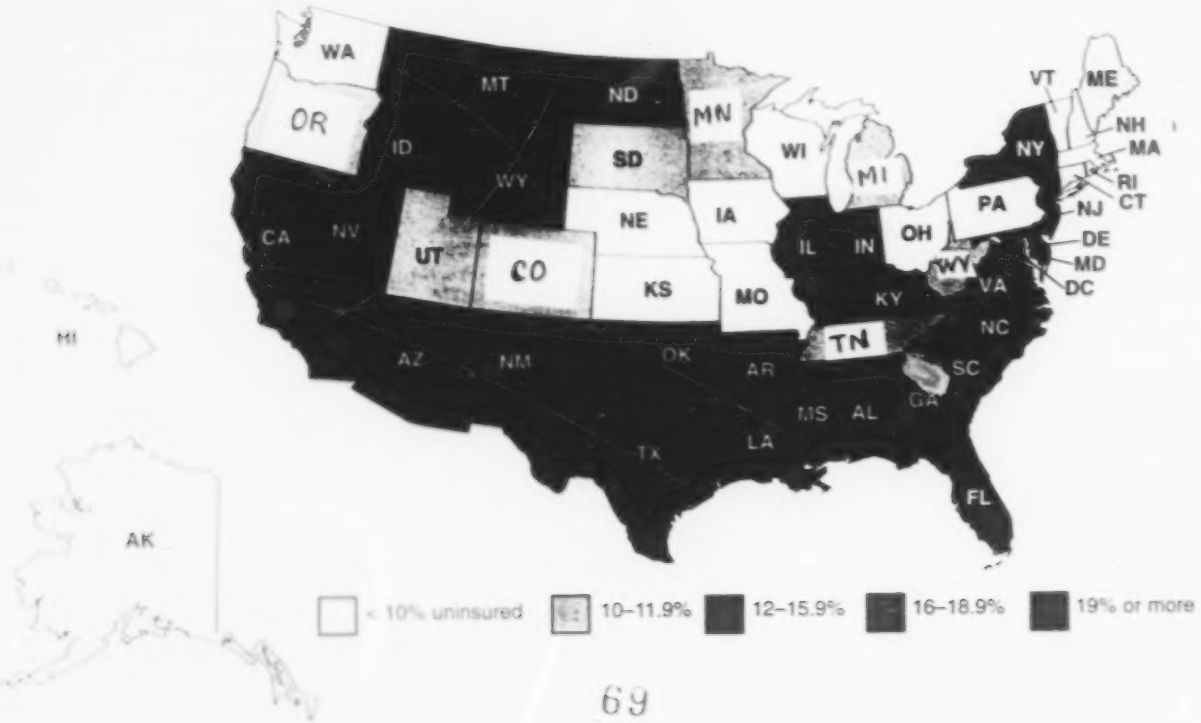
HEALTH INSURANCE STATUS FOR CHILDREN UNDER AGE 19: 1998

State	Percent with Private/Employer-Based Insurance	Percent Enrolled in Medicaid	Percent Uninsured*
UNITED STATES	**64.6**	**19.9**	**15.5**
ALABAMA	61.6	20.9	18.0
ALASKA	66.6	25.1	8.3
ARIZONA	56.5	17.5	26.0
ARKANSAS	63.0	18.2	18.9
CALIFORNIA	56.0	23.2	20.7
COLORADO	80.4	7.8	11.8
CONNECTICUT	73.9	15.1	11.0
DELAWARE	62.1	20.1	17.8
DC	39.8	42.4	17.8
FLORIDA	62.8	18.4	18.7
GEORGIA	55.2	25.5	19.3
HAWAII	71.1	19.3	9.7
IDAHO	63.7	18.7	17.6
ILLINOIS	68.8	16.5	14.6
INDIANA	72.8	11.7	15.5
IOWA	78.2	14.4	7.4
KANSAS	76.1	15.9	8.0
KENTUCKY	67.0	19.2	13.8
LOUISIANA	56.5	25.2	18.3
MAINE	69.6	19.4	11.0
MARYLAND	78.1	4.0**	18.0
MASSACHUSETTS	66.3	25.8	7.9
MICHIGAN	67.3	21.5	11.2
MINNESOTA	73.9	16.0	10.1
MISSISSIPPI	61.8	17.3	20.9
MISSOURI	69.9	21.0	9.1
MONTANA	59.7	22.8	17.5
NEBRASKA	72.6	21.9	5.5
NEVADA	70.3	7.1	22.6
NEW HAMPSHIRE	71.2	19.0	9.8
NEW JERSEY	74.4	11.8	13.8
NEW MEXICO	48.2	36.3	15.5
NEW YORK	58.5	27.3	14.1
NORTH CAROLINA	64.3	22.0	13.7
NORTH DAKOTA	68.6	19.4	12.1
OHIO	72.4	18.5	9.1
OKLAHOMA	60.1	20.5	19.5
OREGON	62.2	25.9	11.9
PENNSYLVANIA	70.1	20.9	9.0
RHODE ISLAND	76.3	15.9	7.9**
SOUTH CAROLINA	69.6	14.8	15.6
SOUTH DAKOTA	70.9	17.4	11.7
TENNESSEE	57.1	32.5	10.5
TEXAS	56.0	18.1	25.9
UTAH	74.6	14.0	11.4
VERMONT	66.7	26.5	6.8**
VIRGINIA	77.0	10.3	12.8
WASHINGTON	68.3	22.2	9.5
WEST VIRGINIA	55.5	34.1	10.4
WISCONSIN	73.6	17.2	9.3
WYOMING	71.3	12.0	16.7

*See map on facing page.
** Standard error is greater than 20% of estimate due to small state sample size.

PERCENTAGE OF CHILDREN UNDER THE AGE OF 19 WHO ARE UNINSURED: 1998



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INFANT AND NEONATAL MORTALITY RATES, BY RACE OF MOTHER AND STATE: 1998

Source (IVI): National Center for Health Statistics

State	Infant Mortality[1]			Neonatal Mortality[2]		
	All***	White	Black	All***	White	Black
UNITED STATES	**7.2**	**6.0**	**14.3**	**4.8**	**4.0**	**9.5**
ALABAMA	10.2	7.7	15.5	6.7	4.5	11.1
ALASKA	5.9	4.7	*	2.9	*	*
ARIZONA	7.5	6.9	20.0	4.8	4.5	13.9
ARKANSAS	8.9	7.6	14.0	5.5	4.7	8.5
CALIFORNIA	5.8	5.3	13.7	3.8	3.6	8.2
COLORADO	6.7	6.4	16.0	4.4	4.3	10.8
CONNECTICUT	7.0	5.6	17.4	5.1	4.2	12.5
DELAWARE	9.6	6.9	18.7	6.9	4.2	15.6
DC	12.5	*	15.5	7.2	*	8.6
FLORIDA	7.2	5.9	12.3	4.5	3.9	8.1
GEORGIA	8.5	6.0	13.4	5.8	4.0	9.4
HAWAII	6.9	5.3	*	5.1	*	*
IDAHO	7.2	7.1	*	4.6	4.5	*
ILLINOIS	8.4	6.4	17.2	5.6	4.5	10.5
INDIANA	7.6	6.5	17.3	5.2	4.3	12.0
IOWA	6.6	6.2	16.3	4.6	4.3	*
KANSAS	7.0	7.0	10.0	4.6	4.7	*
KENTUCKY	7.5	6.8	15.4	4.9	4.5	9.3
LOUISIANA	9.1	5.7	14.0	5.9	3.8	9.1
MAINE	6.3	6.4	*	4.2	4.2	*
MARYLAND	8.6	5.2	15.3	6.2	3.8	11.1
MASSACHUSETTS	5.1	4.9	8.3	3.9	3.7	6.5
MICHIGAN	8.2	6.3	16.8	5.3	4.1	11.0
MINNESOTA	5.9	5.1	13.4	4.0	3.6	8.7
MISSISSIPPI	10.1	6.3	14.8	6.2	3.3	9.7
MISSOURI	7.7	6.1	16.8	4.9	4.0	10.9
MONTANA	7.4	7.2	*	4.2	4.2	*
NEBRASKA	7.3	6.7	19.4	4.8	4.4	*
NEVADA	7.0	6.0	17.3	3.5	2.8	9.8
NEW HAMPSHIRE	4.4	4.3	*	3.4	3.3	*
NEW JERSEY	6.4	5.0	12.8	4.5	3.6	8.8
NEW MEXICO	7.2	6.9	*	4.4	4.3	*
NEW YORK	6.3	5.3	10.9	4.5	3.8	7.3
NORTH CAROLINA	9.3	6.5	17.6	6.4	4.4	12.6
NORTH DAKOTA	8.6	8.2	*	5.4	5.5	*
OHIO	8.0	7.0	14.2	5.4	4.8	8.9
OKLAHOMA	8.5	8.1	13.5	5.4	5.2	8.3
OREGON	5.4	5.3	*	3.2	3.1	*
PENNSYLVANIA	7.1	5.8	15.4	5.0	4.2	10.1
RHODE ISLAND	7.0	6.2	*	5.2	4.8	*
SOUTH CAROLINA	9.6	6.0	16.2	6.7	3.9	12.1
SOUTH DAKOTA	9.1	7.5	*	4.6	4.2	*
TENNESSEE	8.2	6.3	15.0	5.6	4.1	10.8
TEXAS	6.4	5.8	11.6	4.0	3.6	6.8
UTAH	5.6	5.7	*	3.6	3.6	*
VERMONT	7.0	6.8	*	5.8	5.7	*
VIRGINIA	7.7	5.7	14.9	5.4	3.8	11.1
WASHINGTON	5.7	5.2	13.5	3.6	3.3	8.7
WEST VIRGINIA	8.0	8.0	*	4.6	4.4	*
WISCONSIN	7.2	6.0	18.7	5.1	4.2	13.3
WYOMING	7.2	5.8	*	4.5	3.6	*

* Figure does not meet standards of reliability or precision

** Quantity zero

*** Includes races other than white or black

1 Rates are deaths less than one year per 1,000 live births in specified group.

2 Rates are deaths under 28 days per 1,000 live births in specified group.

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CITY DATA

How does the health of infants and children in America's cities compare to that of children nationwide? This section includes data on infant mortality, low birth weight, and prenatal care for women and children who reside in the Nation's central cities with populations over 100,000.

As the following data indicate, the health status of children living in large U.S. cities is generally inferior to that of children in the Nation as a whole. While the infant mortality rate has decreased in both cities and the Nation, a disparity in rates remains. Higher rates of low birth weight contributed to the 1998 city infant mortality rate of 7.9 deaths per 1,000 live births; the national rate was 7.2. The percentage of pregnant women receiving first trimester prenatal care is lower in cities (79.5 percent) as compared to the Nation (82.8 percent). The percentage of women receiving late or no prenatal care is nearly one third higher in cities than in the Nation as a whole (5.1 percent versus 3.9 percent).

The challenge for health care providers and special initiatives is to eliminate these disparities by improving the health status of children in the Nation's cities.

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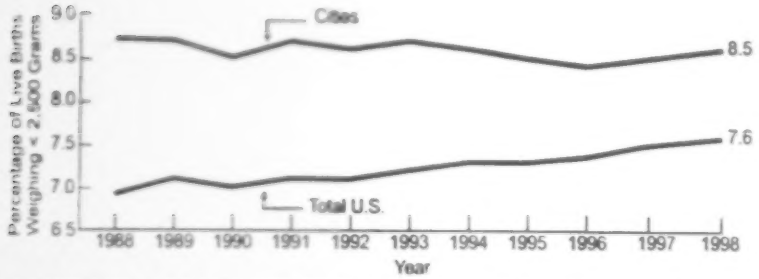
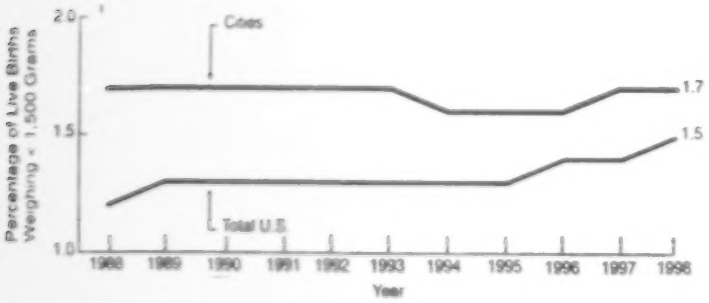
PERCENTAGE OF INFANTS BORN AT LOW BIRTH WEIGHT IN U.S. CITIES WITH POPULATIONS OVER 100,000: 1988-1998

Source (V.1): National Center for Health Statistics



PERCENTAGE OF INFANTS BORN AT VERY LOW BIRTH WEIGHT IN U.S. CITIES WITH POPULATIONS OVER 100,000: 1988-1998

Source (V.1): National Center for Health Statistics



BIRTH WEIGHT

Low Birth Weight

Disorders related to short gestation and low birth weight are the second leading cause of neonatal mortality.* In 1998, 102,477 babies (8.5 percent of all live births) born to residents of U.S. cities with populations over 100,000 were of low birth weight (weighing less than 2,500 grams or 5.5 pounds). The 1998 percentage of urban infants born at low birth weight was 12 percent higher than the national rate of 7.6 percent.

Very Low Birth Weight

Infants born at very low birth weight (less than 1,500 grams or 3 pounds, 5 ounces) are at highest risk for poor health outcomes. In 1998, 1.7 percent of live births in cities with populations over 100,000 were of very low birth weight. This rate exceeded the national very low birth weight rate by 13 percent.

*Congenital anomalies are the leading cause of neonatal mortality.

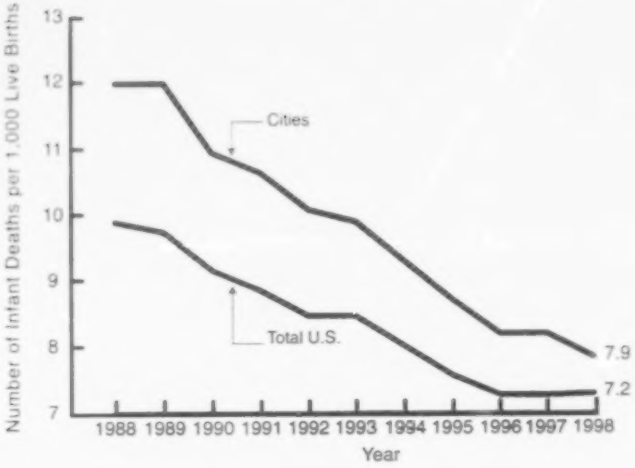
INFANT MORTALITY

In 1998, 9,488 infants born to residents of U.S. cities with populations over 100,000 died in the first year of life. The city infant mortality rate was 7.9 deaths per 1,000 live births, 10 percent higher than the rate of 7.2 for the Nation as a whole. The 1998 rate of 7.9 represents an almost 9 percent decrease in the 1995 city infant mortality rate of 8.7.

Although the infant mortality rate in cities has routinely been higher than the rate in the Nation as a whole, it has steadily declined over the past decade. Between 1988 and 1998, infant mortality in cities declined by roughly one third; the decline nationwide in the same period was 28 percent.

INFANT MORTALITY RATES IN U.S. CITIES WITH POPULATION OVER 100,000: 1988-1998

Source (V1): National Center for Health Statistics



PRENATAL CARE

Early Prenatal Care

Women living in U.S. cities with a population of over 100,000 are less likely to begin prenatal care in the first three months of pregnancy than women nationwide. The gap in early entry into prenatal care between urban women and the nation as a whole has narrowed since 1993.

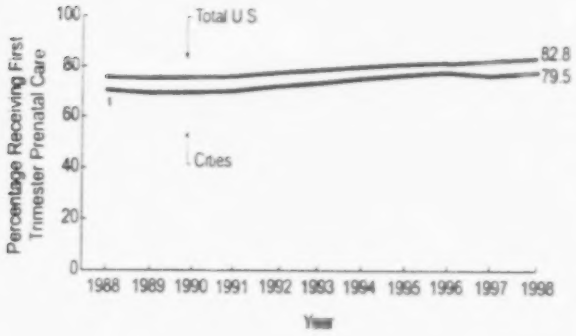
In 1998, 79.5 percent of pregnant women living in U.S. cities began prenatal care in the first trimester of pregnancy, compared to 82.8 percent nationwide. The percentage of women receiving prenatal care has increased steadily since 1989 at both the city and national levels. The Healthy People 2010 Objective is to have 90 percent of pregnant women begin prenatal care in the first trimester.

Late or No Prenatal Care

The percentage of pregnant women living in U.S. cities with a population of over 100,000 who began prenatal care in the 3rd trimester or received no prenatal care remained at 5.1 percent between 1997 and 1998. However, the percentage of women receiving late or no prenatal care is still 31 percent higher among women living in cities than among the overall U.S. population.

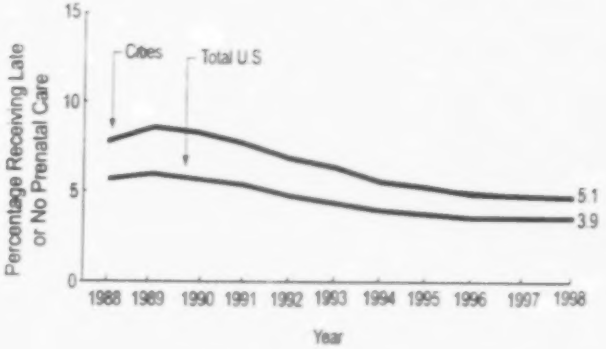
PERCENTAGE OF PREGNANT WOMEN RECEIVING FIRST TRIMESTER PRENATAL CARE IN U.S. CITIES WITH POPULATIONS OVER 100,000: 1988-1998

Source (V1): National Center for Health Statistics



PERCENTAGE OF PREGNANT WOMEN RECEIVING LATE OR NO PRENATAL CARE IN U.S. CITIES WITH POPULATIONS OVER 100,000: 1988-1998

Source (V1): National Center for Health Statistics



HEALTHY PEOPLE 2010 OBJECTIVES FOR THE NATION: MATERNAL, INFANT, AND CHILD HEALTH

Source (VI.1) Public Health Service

Number	OBJECTIVES
	Fetal, Infant, Child, and Adolescent Deaths
16-1	Reduce fetal and infant deaths
1.a.	Fetal deaths at 20 or more weeks of gestation
1.b	Perinatal deaths (28 weeks of gestation to 7 days or more after birth)
1.c.	Infant deaths
1.d.	Neonatal deaths
1.e.	Postneonatal deaths
1.f.	Infant deaths from all birth defects
1.g.	Infant deaths from congenital heart defects
1.h.	SIDS deaths
16-2	Reduce the rate of child deaths
2.a.	Deaths of children aged 1-4 years
2.b.	Deaths of children aged 5-9 years
16-3	Reduce deaths of adolescents and young adults
3.a.	Deaths of adolescents aged 10-14 years
3.b.	Deaths of adolescents aged 15-19 years
3.c.	Deaths of young adults aged 20-24 years
	Maternal Death and Illness
16-4	Reduce maternal deaths
16-5	Reduce maternal illness and complications due to pregnancy
5.a.	Maternal complications in labor and delivery
5.b.	Ectopic pregnancy
5.c.	Postpartum complications, including postpartum depression
	Prenatal Care
16-6	Increase the proportion of pregnant women who receive early and adequate prenatal care

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HEALTHY PEOPLE 2010 OBJECTIVES FOR THE NATION: MATERNAL, INFANT, AND CHILD HEALTH

Source (VT 1) Public Health Service

Number	OBJECTIVES
6.a	Early prenatal care (beginning in the first trimester of pregnancy)
6.b	Early and adequate prenatal care
16-7	Increase the proportion of pregnant women who attend a series of prepared childbirth classes
	Obstetrical Care
16-8	Increase the proportion of very low birth weight babies born at Level III hospitals or subspecialty perinatal centers
16-9	Reduce cesarean deliveries among low-risk (full-term, singleton, vertex presentation) women
9.a	Women giving birth for the first time
9.b	Prior cesarean birth
	Risk Factors
16-10	Reduce low birth weight and very low birth weight
16-11	Reduce preterm births
16-12	Increase the proportion of mothers who achieve a recommended weight gain during their pregnancies
16-13	Increase the percentage of healthy, full-term infants who are put down to sleep on their backs
	Developmental Disabilities
16-14	Reduce the occurrence of developmental disabilities
14.a	Mental retardation
14.b	Cerebral Palsy
14.c	Autism spectrum disorder
14.d	Epilepsy
	Neural Tube Defects
16-15	Reduce the occurrences of spina bifida and other neural tube defects
16-16	Increase the proportion of pregnancies begun with an optimum folic acid level

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EALTHY PEOPLE 2010 OBJECTIVES FOR THE NATION: MATERNAL, INFANT, AND CHILD HEALTH

urce (VT 1) Public Health Service

umber	OBJECTIVES
6.a	Consumption of at least 400 micrograms of folic acid daily from fortified foods or dietary supplements by nonpregnant women aged 15-44 years
6.b	Median red blood cell folate level among nonpregnant women aged 15 to 44 years
	Prenatal Substance Exposure
-17	Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women
7.a	Abstinence from alcohol
7.b	Abstinence from binge drinking
7.c	Abstinence from cigarette smoking
7.d	Abstinence from illicit drugs
-18	Reduce the occurrence of fetal alcohol syndrome
	Breastfeeding, Newborn Screening, and Service Systems
-19	Increase the proportion of mothers who breastfeed their babies
19.a	In the early postpartum period
19.b	At 6 months
19.c	At 1 year
16-20	Ensure appropriate newborn bloodspot screening, follow-up testing, and referral to services
20.a	Screening at birth
20.b	Follow-up diagnostic testing
20.c	Referral to services
16-21	Reduced hospitalization for life-threatening sepsis among children aged 4 years and under with sickling hemoglobinopathies (e.g. sickle cell)
16-22	Increase the proportion of children with special health care needs who have access to a medical home
16-23	Increase the proportion of states and territories that have service systems for children with special health care needs

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CONTRIBUTORS

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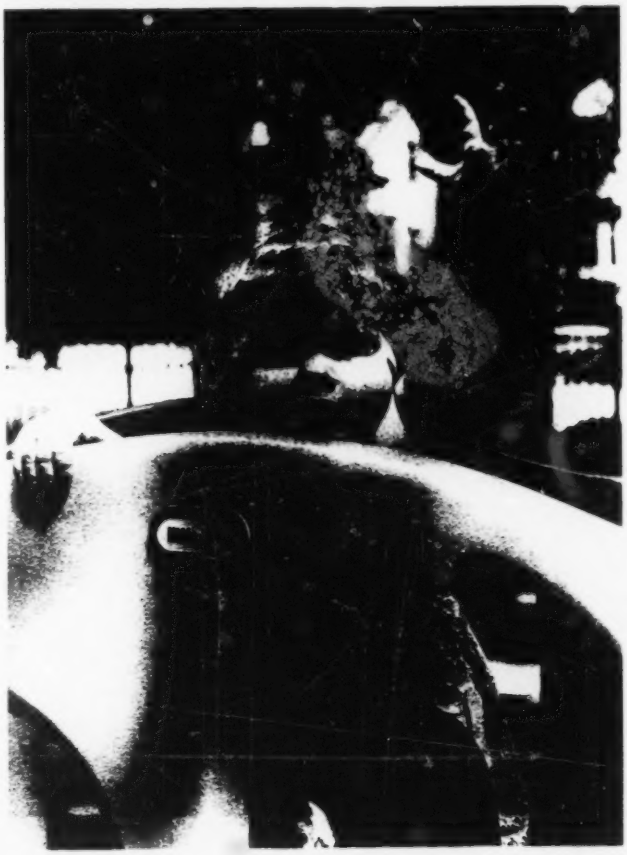

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